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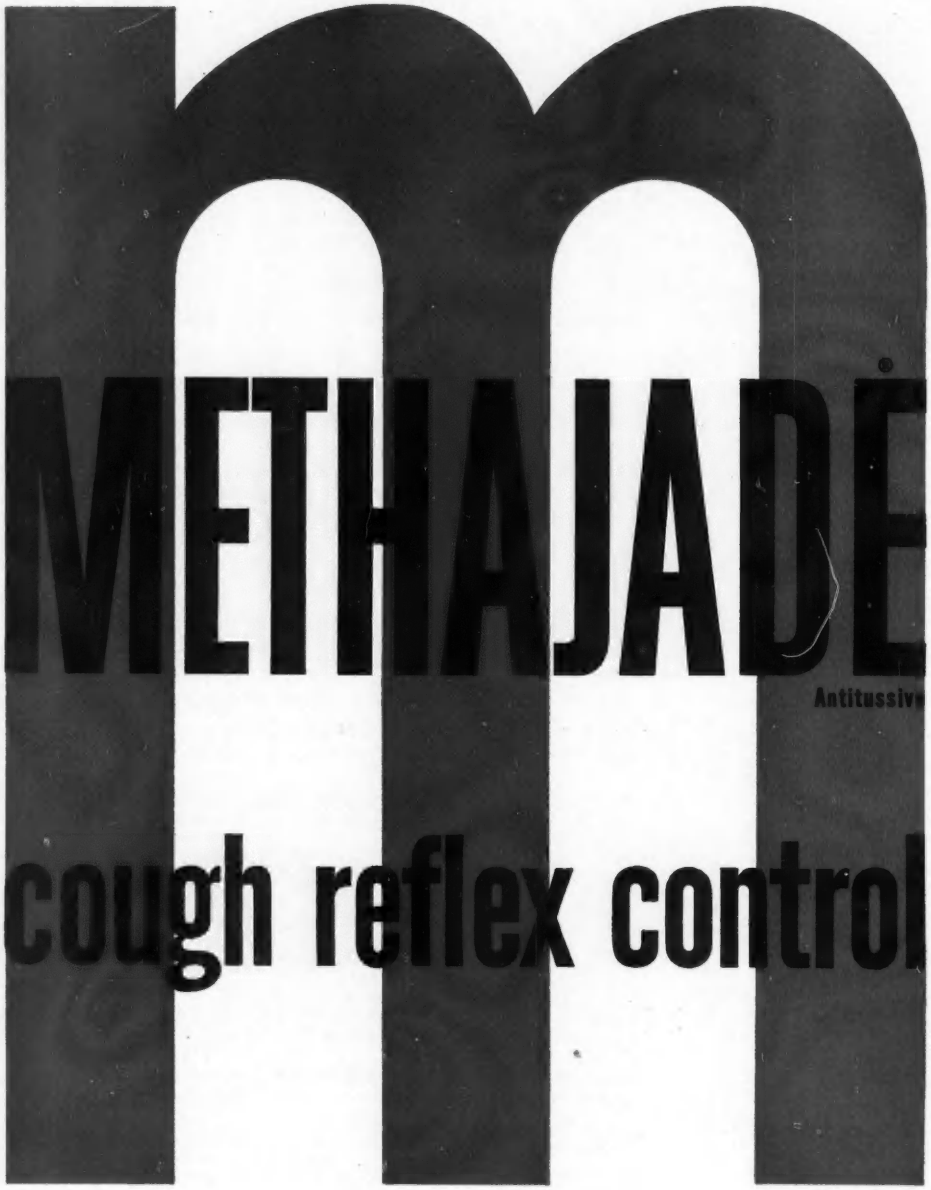

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Medical Management of Renal Lithiasis

Increasing the Protective Urinary Colloids With Hyaluronidase

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SUMMARY

Urine is a highly saturated solution due to the presence of certain colloids. The protective action of urinary colloids is of major importance in preventing precipitation, agglomeration and conglomeration of crystalloids from a super-saturated solution.

If the concentration of such protective colloids is insufficient, stone formation begins or is accelerated. In 680 human subjects, the incidence of stone was found to be almost inversely proportional to the degree of protective urinary colloids present. Urine specimens were subjected to ultramicroscopic examination, determination of electric charge carried by the colloidal particles, determination of the surface tension, and photo-ultramicrographic studies.

Subcutaneous injection of hyaluronidase mixed with physiologic saline solution greatly increases the content of protective colloids in the urine. The colloids are caused to set up to a gel, thereby preventing electrolytes present from crystallizing. They act as excellent dispersing agents and prevent the formation of stone.

Hyaluronidase therapy, using 150 turbidity reducing units every 24 to 72 hours, was effective in preventing calculous formation or reformation during a period of 11 to 14 months in 18 of 20 patients in whom, previously, stones formed rapidly. In a second series of ten patients in whom stones formed rapidly, larger doses of hyaluronidase, averaging 300 turbidity reducing units every 24 to 48 hours, were given. The period of observation at the time of report was from six to ten months. In this group, there was no new stone formation or enlargement of existing stones as evidenced by x-ray studies at 30- to 60-day intervals.

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THE nature and process of kidney stone formation is not completely understood, and the treatment, other than surgical, is still inadequate. The medical management of calculous disease has been primarily directed toward attempts to diminish the concentration of crystalloids excreted in the urine or to free crystalline material from a stone, thus caus-

ing its disintegration. Such therapeutic measures have not proven uniformly successful, with the exception of correcting certain metabolic disorders. Consequently there is great pessimism in the minds of many physicians who are confronted with such problems.

The formation of calculi is a complex process; several concomitant factors are essential in their production. Kidney stones are formed of matter present in two conditions, namely, crystalline and colloidal. They may be defined as concretions composed of urinary crystalloids bound together by and incorporated in a colloidal matrix. Concepts concerning the etiology of stone and consequently its treatment have changed considerably in recent years as the result of intensive laboratory and clinical investigation.[3-8, 10, 11, 13, 16]

The role of protective urinary colloids in the treatment and prevention of stones has, up to quite recently, received little attention. Although Lichtwitz[14] demonstrated the importance of colloids in increasing the solubility of the crystalloidal components in the urine, there is in the medical literature a surprising lack of information concerning further investigation into this problem. Prophylactic and therapeutic efforts have been focused upon preventing the precipitation of colloids and thus indirectly diminishing the formation of urinary deposits.

Colloids or matter in a colloidal state are aggregates of molecules and thus are in a position between the microscopic and molecular dimensions. Their sizes are considered to range from 0.001 Mu to 1 Mu (10^{-7} to 10^{-4} cm.). A colloidal solution, when examined macroscopically or with an ordinary microscope, appears to be clear. It is necessary to view the colloidal particles by reflected light rather than by transmitted light because their dimensions are less than the wave length of visible light. When sols, as these solutions are called, are observed with the ultramicroscope, the colloidal particles appear as bright discs in a state of ceaseless, agitated, zig-zag, erratic, rapid movement known as Brownian molecular motion. The phenomenon constitutes a visual demonstration of molecular kinetic energy. The apparent size of the bright images bears no relationship to the size of the actual particles. It is possible, for practical purposes, to count the number of particles present in the field of the ultramicroscope and thus determine the number in a known volume of fluid (field diameter approximately 0.002 mm.; volume 1 x 10^{-9} ml.).

If the particles of a substance are reduced in size until the dimensions become submicroscopic and are distributed throughout a second medium, they develop characteristic properties attributable to the enormous suface area of the dispersed phase. It has been estimated that one gram of colloidal material in urine has a surface area of approximately 5,000 square meters. One of the most important results of this large surface is the unsaturation of ions located in the surface, causing adsorption of ions dispersed

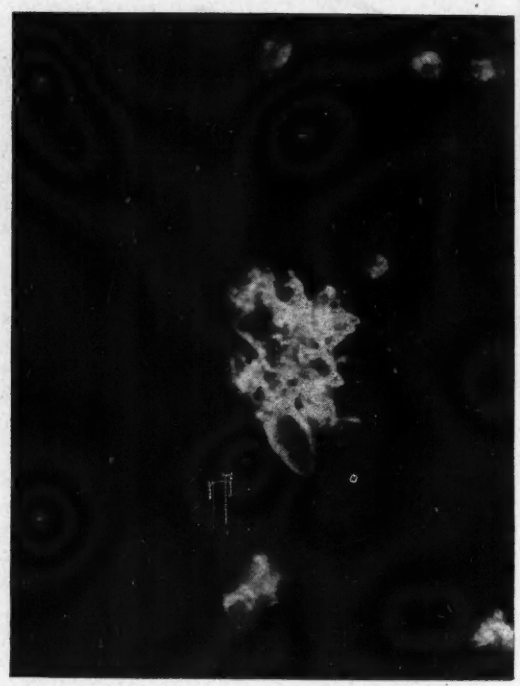

Figure 1.—Ultropak microscopic view × 2,500. Beginning of kidney stone formation by crystallization of urine in white male with rapidly forming bilateral, calyceal stones.

in the surrounding medium and carrying an electric charge of opposite sign. This leads to the formation of electrical charges around the particles, preventing the formation of larger aggregates. Another important factor in preventing precipitation and agglutination of colloids and crystalloids is that sedimentation of finely divided material may be almost entirely counteracted by the Brownian motion of the colloidal particles. Because of the extreme minuteness of colloidal particles, forces come into play which are negligible in greater dimensions. Such forces are dynamic, not static factors.

Urine is a highly saturated solution of extremely complicated composition, in which electrolytes, as well as non-electrolytes, are dissolved in much higher concentration than their solubility in water would indicate. The reason for this is that urine of a healthy person contains colloids which prevent the precipitation of substances in such super-saturated solutions, as long as their degree of dispersity is sufficiently pronounced. It is the protective action of these colloids which is important in preventing precipitation, agglomeration and conglomeration of crystalloids. If the concentration of such protective colloids is insufficient, however, then the crystal nuclei are "sensitized" and stone formation begins or is accelerated (Figure 1).

From what is known of the effect of colloids in increasing the solubility of stone-forming salts and

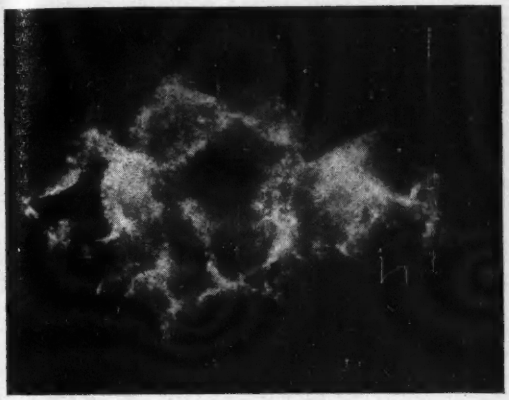

Figure 2.—Ultropak microscopic view, × 2,500. Urine deposit of white male who had constant symptoms of kidney stones. This picture was taken ten minutes after hyaluronidase had been injected. It clearly shows the almost immediate reaction to this medication, because now the solid particles have all become the dispersed part of a jelly-like cluster.

preventing their precipitation, it is logical to assume that if their protective power is diminished or absent, urinary deposits will form more readily. This mechanism probably also applies to other types of calculous formation, whether in the teeth, salivary ducts, pancreas, gallbladder or prostate gland.

During the time that one of the authors (A.J.B.) was stationed on various islands in the Pacific Ocean during World War II, he had an excellent opportunity to study the incidence of stone formation among persons of many different ethnic groups and nationalities. From these observations, and from further investigations in West Florida, which is an area of high stone incidence, it became evident that the only common factor whch applied in the majority of cases was that of the presence or absence of protective urinary colloids in the various cases studied.[3-8] The significance of urinary colloids in the relationship to stone formation was further investigated in a series of 680 subjects.

Specimens of urine were obtained aseptically from both male and female patients and were subjected to ultramicroscopic examination, determination of electric charge carried by the colloidal particles, and determination of the surface tension. The most characteristic specimens were subjected to photo-ultramicrographic studies. For the ultramicroscopic examination, the "colloidal activity" was graded from zero to four; zero representing no colloidal activity; grade one minus, one to two colloidal particles intermittently present in the field; grade one, one to five particles constantly present in the field, grade two, six to ten particles per field; grade three, 11 to 20 particles per field; and grade four, over 20 particles per field.

In the ultramicroscopic studies it was noted that the degree of colloidal activity present in urine samples from which all extraneous sources of colloidal material had been excluded, was almost inversely

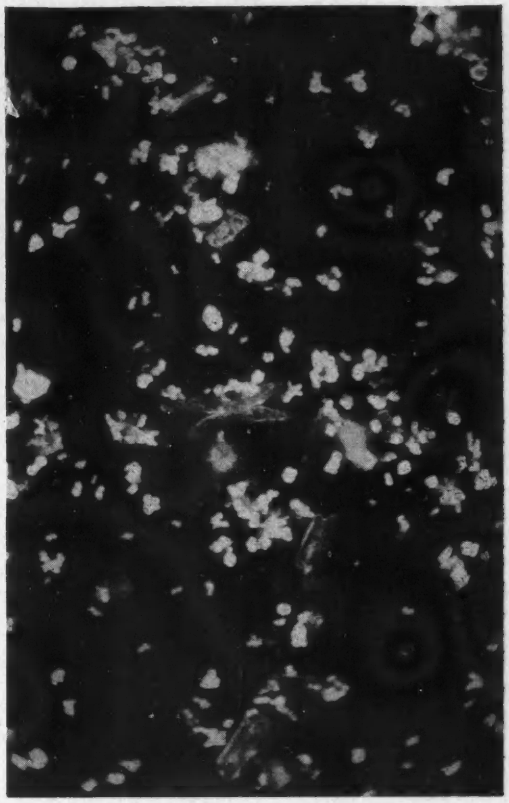

Figure 3.—Ultropak microscopic view, × 2,500. Urine deposit of white male in whom calyceal stones rapidly form bilaterally. Besides a few large crystals, the urine is full of solid crystal micelles which tend to aggregate and eventually grow into larger stones.

proportional to the incidence of stone.[5-8] In the urine of Negroes (who are relatively immune to calculous disease) there was considerably greater colloidal activity than in urine from white subjects. In a series of 250 cases of kidney stones observed during a period of three years, there were only six cases, or 2.4 per cent, in Negroes. Approximately 10 per cent of all patients observed were Negroes. Excretory radiographic studies were routinely made on all private and charity patients.

The urine of females generally had a higher concentration of ultramicroscopically detectable particles than that of males. In practically all statistical series, the incidence of stone is significantly higher in males than in females. In a series of 250 cases of renal lithiasis observed by the authors, there were 167 males and 83 females. The concentration of ultramicroscopically visible colloidal particles in urine from pregnant women greatly surpassed the concentration of such colloidal particles in urine of non-pregnant women. In an analysis of collected series of 49,000 obstetrical cases from various parts of the United States, it was noted that only 15, or 0.03 per cent, were complicated by stone.[2, 9, 12, 15] A par-

turient woman, with dilatation and stasis of the urinary tract, often complicated by infection, is usually well protected against formation of stone. This would indicate that pregnancy does not predispose to calculous disease, but actually aids materially in preventing stone formation.

Surface tension determinations were made with the pendant drop method[1] from urine of various patients after it had been subjected to ultracentrifuging, whereby all matter visible in the ultramicroscope was removed. The results clearly demonstrated that urine of white females had a considerably higher surface tension than that of Negro females. The surface tension of urine of both white and Negro females decreased during pregnancy. In addition, it was noted that the amount of colloidal particles visible in the ultramicroscope significantly increased as pregnancy progressed.

In electrophoretic studies of the non-centrifuged samples of urine it was observed that urine which had a low surface tension had all been obtained from patients who were free of stone, or those who were relatively immune to stone, such as Negroes. This would indicate quite clearly that this favorable condition is attributable to the presence of capillary-active lyophilic colloids. The presence of these capillary-active agents is the predominant factor in preventing the precipitation and conglomeration of crystalloids and thus preventing the formation of stones. This is due to their acting as excellent dispersing agents and protective colloids which form a reversible gel, which prevents the formation of stone from solid crystals of inorganic matter (Figure 2).

While seeking a protective colloid that is excreted in the urine, it was found that hyaluronidase (Wydase®) not only appreciably reduces surface tension, but, when mixed with physiologic saline solution and injected subcutaneously, also acts to disperse minute particles suspended in urine and will prevent stone formation. This is due to the fact that it causes the natural urine colloids and abundant physiologically increased protective urinary colloids to set up to a gel, thereby preventing the electrolytes present from crystallizing.

Chart 1.—Structural formula of hyaluronic acid.

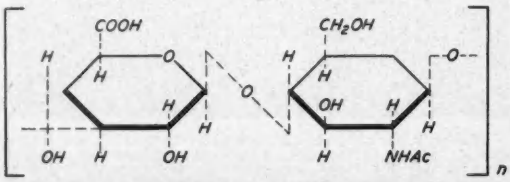

Figure 4.—Ultropak microscopic view, × 2,500. Urine deposit of the same patient as in Figure 3, thirty minutes after hyaluronidase had been injected. To be noted is the complete reaction of this drug, as now the solid particles have all become the dispersed part of a jelly-like cluster and cannot further aggregate and eventually grow into larger stones.

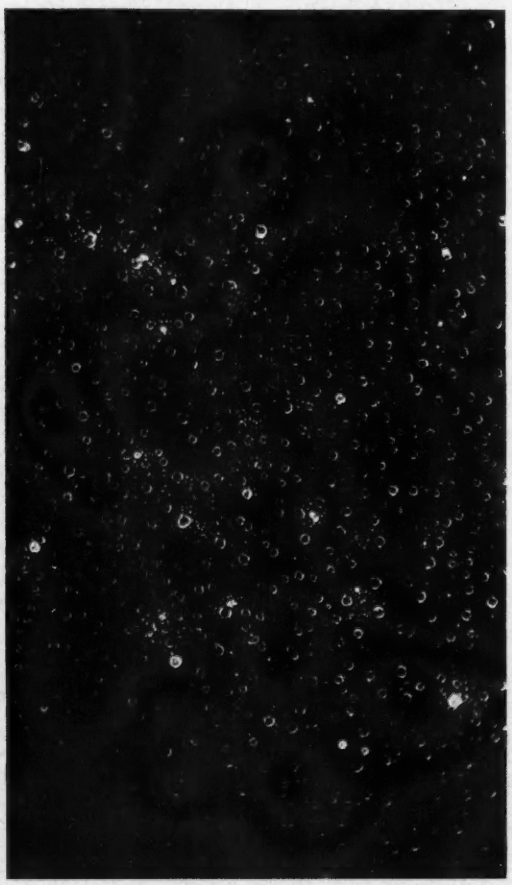

Figure 5.—Ultropak microscopic view, × 2,500. Urine sediment of patient with parathyroid adenoma and multiple, bilateral, renal calculi. The urine is full of solid aggregates of ultramicroscopic-sized unprotected colloidal particles, which tend to conglomerate and eventually grow into larger stones of clinical importance.

Hyaluronidase is an enzyme whose molecular weight has been estimated to be between 60,000 and 70,000. Oxidizing and reducing agents destroy its activity. Hyaluronic acid, a substrate of hyaluronidase, is a linear or spiral polymer whose molecular weight has been estimated at from 200,000 to 2,000,000. It is composed of alternating units of acetyl glucosamine and glucuronic acid (Chart 1). It is a viscous mucopolysaccharide, which in animal tissue seems to bind with water in interstitial spaces, holding cells together in a jelly-like matrix. Hyaluronidase releases hyaluronic acid at the site of injection. The weakened barrier begins to reconstitute itself as the hyaluronidase action is dissipated. During the period of repair, excess hyaluronic acid or a substrate is present in the blood and is excreted in the urine. The effect of hyaluronidase on increasing protective urinary colloids is an indirect one as the hyaluronic acid, or one of its products, when released, is excreted in the urine, thus acting as a protective colloid.

The clinical application of increasing protective colloids by parenteral injection of hyaluronidase is a new concept in the treatment and prevention of renal lithiasis. The first 20 patients subjected to the treatment had multiple, bilateral, and rapidly recurring renal calculi. They had passed numerous stones at regular intervals over a period of years and new stones developed within a period of weeks or a few months. In these patients, no regimen of therapy had been effective in reducing the formation or reformation of stone before hyaluronidase therapy was instituted. Subcutaneous injection of 150 turbidity reducing units of hyaluronidase mixed with 1 cc. of saline was regulated individually by observing the duration of increased colloidal activity after injection of the drug, so that this protective activity was maintained at an increased level. This varied from 19 to 120 hours and the average was from 24 to 72 hours. Each patient was investigated with regard to all known etiological factors as relates to stone formation. At the time of this report these patients had been receiving hyaluronidase therapy for from 11 to 14 months and no other form of therapy to combat stone formation had been employed during that time. In 18 of these 20 patients (90 per cent), no new stone formation or increase in size of existing stones occurred when the drug was taken properly, as is evidenced by roentgenograms taken at 30-day to 60-day intervals. A second series of ten patients, in all of whom stones formed rapidly, received larger doses of hyaluronidase, averaging 300 turbidity reducing units every 24 to 48 hours. At the time of this report, after periods of treatment ranging from six to ten months, there was no new stone formation or increase in size of existing stones, as evidenced by x-ray films taken at 30- to 60-day intervals. Three cases are summarized and only significant findings are noted.

Figure 6.—Ultropak microscopic view, × 2,500. Deposit in urine of same patient as in Figure 5 thirty minutes after injection of hyaluronidase. Now forming in the urine are only highly solvated gel clusters which are readily redispersed when diluted.

REPORT OF THREE CASES

Case 1. A 34-year-old male had had symptoms for seven years. Stones composed of calcium phosphate and ammonium magnesium phosphate were passed at intervals of one to five months. The degree of protective urinary colloidal activity was extremely low (Figure 3). In roentgenograms, innumerable, bilateral calyceal stones were noted. Hyaluronidase therapy was started October 2, 1950. X-ray films were taken at intervals of one to two months and there was no evidence of new stones or growth of existing stones during the 11 months after therapy was begun. Protective urinary colloids were maintained at an elevated level (Figure 4). The patient passed stones on two occasions when therapy was discontinued for three weeks each time. Otherwise, he was asymptomatic.

Case 2. A woman, 50 years of age, who had had symptoms for 25 years, passed stones composed of calcium phosphate at intervals of one to three months. The protective urinary colloid content was extremely low (Figure 5). In roentgenograms, innumerable bilateral calyceal stones were observed. The serum calcium content was 14.2 mg. per 100 cc. and the phosphorus content was 1.9 mg. per 100 cc. In a 24-hour urine specimen, the calcium content was 1.1 gm. per 100 cc. Hyaluronidase therapy was started December 12, 1950. X-ray films were taken at three- to four-week intervals and no new stones or growth of existing stones

Figure 7.—Ultropak microscopic view, × 2,500. Urine sediment from a white female with bilateral, renal calculi, and a severe urinary tract infection. The urine is full of aggregates of colloidal particles (non-protective colloid composed of degradation products of leukocytes, erythrocytes, bacteria and exudates) and one crystal near the center of the plate.

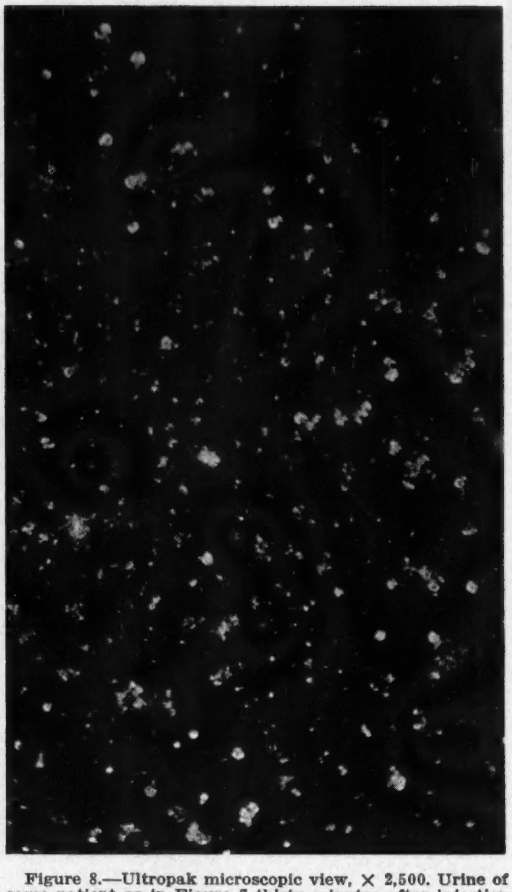

Figure 8.—Ultropak microscopic view, × 2,500. Urine of same patient as in Figure 7 thirty minutes after injection of hyaluronidase. Now forming in the urine are only highly solvated gel clusters which prevent further agglomeration and conglomeration of crystalloids.

was noted after therapy was begun. Urinary protective colloids were maintained at an elevated level (Figure 6). The patient passed no stones and had no symptoms after treatment was started.

CASE 3. A woman 36 years of age who had had symptoms for five years passed stones composed of calcium phosphate and ammonium magnesium phosphate every two to three months. The content of protective colloids in the urine was low (Figure 7). Bacillus coli grew on a culture of the urine. A cluster of small stones in a dilated lower calyx on the left side and multiple small calyceal stones in the right kidney were observed in roentgenograms. Hyaluronidase therapy was started and protective urinary colloids were maintained at an elevated level (Figure 8). X-ray films were taken every one to two months and there were no new stones or enlargement of existing stones after nine months. There were no symptoms after hyaluronidase therapy was started.

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Cardiac Arrest During Anesthesia

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SUMMARY

In cases of acute cardiac arrest from transient or reversible causes resuscitation is a distinct possibility. Prompt action is of the utmost importance.

The sequelae of cardiac arrest will depend on the degree of anoxia that has developed and the amount of irreversible damage to brain tissue. Efficient manual artificial circulation, begun immediately, can prevent such damage.

Four cases of cardiac arrest are described. Sudden circulatory collapse, which may or may not imply cardiac arrest, is not uncommon during surgical procedures. Usually the patient recovers quickly when treatment is prompt.

WHEN does death occur? There is no immediate criterion indicative of the transition from life to death. Years ago, cessation of respiration was considered synonymous with death. It was a common practice to hold a mirror in front of a patient's face and if there was no condensation of moisture from exhaled air, he was pronounced dead. When it was realized that the artificial maintenance of respiration could prevent death, the fallacy of this view became apparent. Cessation of cardiac activity superseded cessation of respiration as the criterion of death. But again a fallacy became apparent. Some patients were revived after cardiac arrest. Jut as a community is not dead when its transportation system fails, so the body is not dead when respiration or circulation fail. But just as a community will disintegrate and cease to be a community when the resulting starvation ravages its population and disrupts all coordinated effort, so it is with the body when the effects of respiratory or circulatory failure result in irreparable damage. Death does *not* occur until after there has been so much irreversible damage to nervous tissue that restoration of coordinated vital functions is impossible.

Respiratory arrest and cardiac arrest are very similar functional disorders and the principles applicable to one are equally applicable to the other. The apparent differences are chiefly those of relative urgency and relative accessibility. Depending on circumstances, respiratory arrest may persist from perhaps two to twelve minutes before irreversible damage results, because the oxygen in the lungs and blood acts as a reservoir. On the other hand, cardiac arrest will probably result in some irreversible damage in from two to four minutes. To counteract respiratory arrest by artificial respiration requires only moments because the respiratory mechanism is accessible. To counteract circulatory arrest by manual circulation is likely to require minutes. The margin of safety in this condition is much narrower.

It is fairly obvious that if the heart fails because of irreversible contributing circumstances such as severe hemorrhage, shock, or embolus, efforts at cardiac resuscitation are well-nigh hopeless. On the other hand, in cases of acute cardiac arrest from transient or reversible causes, resuscitation is a distinct possibility and any restorative measure, no matter how drastic, is justifiable.

As stated by Thompson and co-workers,[8] "acute cardiac cessation is conveniently classified into two groups: (1) arrest of stimulus formation or the so-called pace-maker failure, the result of which is cardiac standstill and (2) electrodynamic dissolution of the cardiac cycle, of which ventricular fibrillation is an example." The chances of successful resuscitation are greater in the case of cardiac standstill than in the case of ventricular fibrillation. Fortunately most cases fall into the former group. It is impossible to differentiate the two clinically unless the heart is already exposed or an electrocardiogram is in process.

ETIOLOGY

There are various circumstances which may lead to acute cardiac arrest:

1. *Reflex arrest* due to vagovagal stimulation. Such stimuli may arise from surgical trauma in the region of the aorta, the hilus of the lung, the carotid sinus or the vagus nerves. Weeks and co-workers[10] reported a case of cardiac arrest immediately following section of the vagus. It may also result from traction reflexes. Similarly, it has been postulated that anesthetic procedures irritating the tracheobronchial tree, such as intubation, may on occasion excite such reflexes. In certain cases, patients may be put into peculiar positions which result in reflex cardiac arrest.

2. *Direct trauma* to the heart, such as may occur during operations on the pericardium or heart or may be caused by inadvertent pressure of retractors on the heart or aorta, may cause cardiac arrest.

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Presented before the Section on Anesthesia at the 80th Annual Session of the California Medical Association, Los Angeles, May 13 to 16, 1951.

3. *Overdosage of anesthetic agents* may depress the circulation, either by direct effect on the heart or by vasodilation. Chloroform, ethyl chloride and cyclopropane may have direct effects on the heart, particularly by altering the conduction mechanism or, in the case of chloroform and ethyl chloride, by direct depression of the myocardium.

4. *Ventricular fibrillation.* The heart, sensitized by certain anesthetic agents, may react by ventricular fibrillation if subjected to an overdose of epinephrine. This epinephrine may be introduced by injection or may be endogenous, coming from the adrenal glands if there is stimulation or excitement during light anesthesia.

SIGNS OF CARDIAC ARREST

It is sometimes difficult to be certain whether the heart has actually stopped during a surgical procedure or whether its beats are so feeble that there is little evidence of circulation. Therefore all possible means should be utilized to make a rapid evaluation of the situation. The following points should be observed:

1. *Absence of pulsation.* If the anesthetist is feeling the pulse at the time cardiac arrest occurs, he will notice the sudden absence of pulsation. More often, however, other indications precede this and call the anesthetist's attention to the emergency. He then attempts to feel the pulse but finds that he cannot detect it. There will also be no visible pulsation in the neck. The surgeon may have access to a large artery which he may palpate to determine if there is any pulsation.

2. *Absence of blood pressure.* If attempts are made to determine the blood pressure, it will be found that no audible or visual pulsations occur.

3. *Respiratory arrest.* The most common initial indication of cardiac arrest is the almost immediate cessation of respiration due to cerebral anoxia. There may be a few gasps preceding this. In all cases of respiratory arrest, one of the anesthetist's first obligations is to feel for the pulse and determine if the circulation is satisfactory.

4. *Pallor or cyanosis* quickly follows cardiac arrest. The actual color will depend somewhat on the peripheral distribution of blood, and the position of the patient is a factor. The blood will gravitate to the dependent parts of the body. If the head is elevated, pallor of the upper part of the body may be expected. If the head is lowered, congestion and deep cyanosis may develop.

5. *Cardiac sounds* cannot be heard over the precordium.

6. *Absence of bleeding* in the wound may be observed. The surgeon may be requested to incise a moderate-sized artery to see if it will bleed.

7. *Direct observation of heart.* If the surgeon is performing a transthoracic operation, he may observe the state of the heart directly. If he is performing an abdominal operation, he may palpate the heart from below the diaphragm.

8. *Dilation of the pupils* may develop as anoxia progresses.

9. *The capillary refill time* as determined by pressure on the skin, and the duration of the resulting pallor, may be of some significance.

PROPHYLAXIS

Since in many cases cardiac arrest results from vagal stimulation, it is advocated that adequate atropinization be used when there is serious likelihood of stimulation in one of the more sensitive areas. Similarly, blocking of the afferent stimuli by infiltration with a local anesthetic agent in areas such as the hilus of the lung may prevent the condition. In cases in which trauma near the hilus of the lung, the heart or the pericardium causes arrhythmia, the injection of 5 cc. to 10 cc. of 1 per cent procaine solution intravenously may relieve the condition and prevent cardiac arrest. Direct application of procaine to the heart during cardiac operations is sometimes utilized, although the value of this is more questionable.

TREATMENT OF ACUTE CARDIAC ARREST

As has been emphasized by Bailey,[2] time is of the utmost importance and a preconceived plan of action should be followed in order to avoid any unnecessary delay. Bailey stressed the value of keeping an accurate check on the time which has elapsed from the onset of the emergency, and he advocated that one person in the operating room be delegated at once to be the time-keeper and to call off the passing minutes. Whether this is done or not, it is vitally important that the duration of the emergency be carefully observed and that the routine of action be gauged according to the time which has elapsed. All anesthetists should have some such routine in mind, and it will probably be found that surgeons will respond and cooperate if the anesthetist demonstrates his knowledge of the situation and his competence to direct procedures. The following is an outline of a routine which may be followed.

1. *Immediate.* As soon as cardiac arrest is suspected, several things should be done almost simultaneously. Since only a matter of seconds need elapse until all are instituted, the exact order is unimportant:

(a) Notify the surgeon of the suspected emergency.

(b) Lower the head of the table to a Trendelenburg position of 10 to 15 degrees.

(c) Discontinue the administration of the anesthetic agent and substitute pure oxygen or air.

(d) Correct any situation which has possibly contributed to the emergency. The possibility that an anesthetic agent is being administered inadvertently, as by leaving the valve of an ether bottle open, should be considered. Patients have died because anesthetists have persisted in resuscitative efforts without realizing that they were continuing to administer a hgh concentration of ether or that they were erroneously using nitrous oxide instead of

oxygen. Any recent manipulation by the surgeon which might have precipitated a vagovagal reflex should be discontinued. Any change of position which has been followed by circulatory collapse or cardiac arrest should be corrected.

(e) The anesthetist should immediately look at his watch and make an accurate note of the time of onset of the emergency. An alternative is to follow Bailey's method and delegate someone in the room to watch the time.

(f) Most important of all, artificial respiration should be instituted at once and continued throughout, with two exceptions noted below. If the anesthetist is sure that there is no error in the apparatus, inflation of the lungs with pure oxygen by means of pressure on the breathing bag is a desirable method. If he is in doubt about the machine or does not have one immediately available, then mouth-to-mouth or mouth-to-nose respiration is the best substitute. If the patient is anesthetized with an agent which is eliminated through the lungs, provision must be made for a free elimination of the exhaled atmosphere. Thus, in case of overdosage of an inhalation agent, one must not use the carbon dioxide absorption technique with only a maintenance flow of oxygen. The technique may be used but there must be a sufficiently rapid flow of oxygen (at least six liters per minute) to provide rapid elimination of the exhaled atmosphere. It was observed in animal experiments by Thompson and co-workers[8] that artificial respiration with alternating positive and negative pressures, such as is produced by certain resuscitators, is more effective in restoring cardiac activity than mere intermittent inflation. However, such resuscitators may not be available. Artificial respiration by means of positive pressure has a distinct effect in producing some peripheral circulation. This is brought about by the increased intrathoracic pressure compressing the heart and squeezing the blood out. Although in some cases cardiac arrest may be relieved merely by this form of cardiac stimulation, it must not be assumed that vital functions are maintained by this propulsive effect on the blood. Volpitto and co-workers[9] demonstrated that the two most important parts of the circulation—namely, that in the cerebral and in the coronary arteries—are not influenced by this kind of artificial circulation.

If possible, an endotracheal tube should be inserted. However, delay for this procedure cannot be countenanced unless inflation of the lungs is otherwise impossible because of obstruction. The endotracheal tube has several advantages. It insures a free respiratory exchange and it obviates the possibility that the stomach may be inflated with oxygen which passes down the esophagus.

2. *During the first minute.* If positive evidence of cardiac arrest is not immediately available, the first minute may be occupied with efforts to determine the actual situation. If the surgeon can immediately feel or see the heart and verify its inactivity, the procedure described under (4) below should be started immediately. Occasionally an arrested heart may be stimulated by thumping over the precordium. Therefore this type of stimulation may be attempted during the first minute but it should not in any way supersede the other efforts described.

3. *During the second minute.* If evidence of cardiac activity has not been elicited, it should be assumed that there is cardiac arrest and this minute should be utilized to make preparation for gaining direct access to the heart, either through an upper abdominal or thoracic incision. The surgeon should be notified of the necessity for this and should make his preparations. If possible, the field should be disinfected and sterile drapes and instruments obtained. However, since nothing can take precedence over the problem of reestablishing circulation, these details may be modified according to facilities available. During this minute, further observations regarding pulse, heart sounds, etc., are made so that if cardiac activity resumes it will be noted.

4. *During the third minute.* If, at the end of two minutes, there is still no evidence of circulation, the surgeon should proceed with the incision which he has elected and gain access to the heart. If, under direct observation or palpation, no heart beat is apparent, manual artificial circulation should be instituted and maintained until spontaneous contractions return or all efforts are considered to be of no avail. The rhythmical squeezing of the heart has two purposes: first, to propel blood and maintain circulation and, second, to stimulate the cardiac muscle in the hope of restoring spontaneous activity.

When artificial respiration and manual artificial circulation are maintained, the urgency of the situation is relieved. Oxygenation of vital tissues is maintained. Ample time may be taken to relieve the cardiac arrest by other means if necessary. Adams and co-workers[1] reported successful resuscitation with complete recovery after 20 minutes of cardiac arrest. It must be emphasized that in that case the heart was under direct observation and manual artificial circulation was instituted immediately after the arrest occurred so that oxygenation of the tissues was not impaired throughout the 20 minutes. (It is well to note in passing that the term "cardiac massage," which so often is used to describe the manual rhythmical squeezing procedure, is misleading. In one case, to be described later, an orthopedic resident heroically responded to the anesthetist's request that an abdominal incision be made and "cardiac massage" performed. However, it appears that the manipulation he carried out was indeed "massage" in the generally understood meaning of the word.)

The surgical approaches to the heart are (1) transperitoneal, either subdiaphragmatic or transdiaphragmatic; and (2) transthoracic, either extrapleural or intrapleural.

For the subdiaphragmatic approach, a high midline or left paramedian incision should be made. The surgeon then inserts one hand under the diaphragm and places the other over the precordium. The heart is then squeezed between the hands forc-

ibly and rhythmically at the rate of about 60 times per minute. As this method is tiring and not completely efficient, the transdiaphragmatic approach may be added: The diaphragm and adjacent pericardium are incised to permit one hand to be inserted. The heart is grasped in it and rhythmic squeezing continued.

The transthoracic approach is regarded as the one of choice by Barber and Madden.[3] Naturally, if an intrathoracic operation is in progress, this provides a transpleural approach, and access to the heart is obtainable immediately. If it is necessary to incise the thorax, the following method described by Barber and Madden is simple and satisfactory: "Exposure of the heart through a transverse incision in the third or fourth interspace is adequate and readily performed. The incision extends from the anterior surface or left border of the sternum, transversely to the left nipple or anterior axillary line. The incision is deepened through the underlying fascia and muscle layers and the corresponding intercostal space. The adjacent costal cartilages above and below are sectioned and the corresponding ribs widely retracted. The production of pneumothorax is avoided if possible, but it is of no undue consequence if it should occur."

This approach has several advantages. It permits direct observation of the heart so that its actual condition can be verified, and direct application or injection of drugs is facilitated. The maintenance of manual artificial circulation is easier because of the more adequate access to the heart.

5. *Ventricular fibrillation.* If ventricular fibrillation is apparent on inspection of the heart or if it is seriously suspected, certain specific measures aimed at stopping the fibrillation may be instituted. One is to inject 5 to 10 cc. of 1 per cent procaine solution into the right auricle or the left ventricle. This reduces the irritability of the myocardium and facilitates response to normal pace-maker activity. Another method is the use of electrical stimulation of the heart, as done in animal experiments by Prevost and Battelli[7] and as described for application to humans by Beck.[5] Two large electrodes are placed on opposite sides of the heart and shocks of 1 to 1.5 amperes produced. The shock is applied for a fraction of a second. If one shock does not stop ventricular fibrillation, a second and third may be given.

6. *Analeptic drugs.* With artificial respiration and manual artificial circulation in progress, there is no urgency about using other and perhaps hazardous methods. However, intracardiac injection of an analeptic drug may be resorted to if other measures appear to have no effect. The mere passage of a needle through the myocardium may be sufficient to stimulate normal cardiac activity. The injection should be made into the right auricle, since this brings the stimulus near to the pace-maker. A 4½-inch needle should be inserted through the second or third intercostal space immediately to the right of the sternum and directed posteriorly and inferiorly until blood can be withdrawn from the cavity of the heart. The injection is then made. Some investigators have suggested the injection of some of the analeptic drug into the myocardium. However, if epinephrine is used, there is some danger that it may result in local ischemia and infarction. Trauma to a coronary artery caused by the needle, although unlikely, can occur. Sequelae of such a complication should be kept in mind postoperatively. Analeptic drugs suggested have included epinephrine, Coramine® and Metrazol.® There is a tendency to give too much; 0.5 cc. of epinephrine in 1:1,000 solution should be sufficient. If there is no response in a reasonable time, the injection may be repeated. In many cases the injection of epinephrine into the heart has been used before resorting to manual artificial circulation, and in some instances it has proved effective. However, there are reasons why this is injudicious and the apparently more radical method of gaining direct access to the heart should have priority. In the time taken to obtain and to inject epinephrine and in the further delay to see if it has been effective, anoxemia may progress to the point of causing irreversible damage before manual artificial circulation is eventually instituted. Also, epinephrine may cause ventricular fibrillation. Thus if it is injected into a heart which is still beating feebly or which is in standstill, it may cause ventricular fibrillation from which there is much less likelihood of recovery.

The addition of even low concentrations of carbon dioxide to the inhaled atmosphere has been observed by Eastman and Kreiselman[6] to be detrimental.

7. *Interruption of artificial respiration.* As previously mentioned, there are two occasions during which the artificial respiration, otherwise maintained continuously, should be interrupted. One is during the incision of the chest wall or abdominal wall. If the chest wall is being incised, inflation of the lung may result in inadvertent incision of the pleura and lung. During incision of the abdominal wall, respiratory movements may increase the possibility of accidental incision of the stomach. Incidentally, if the lungs have been inflated during the procedure without an endotracheal tube being in place, there is every likelihood that the stomach will be distended and it is advisable to warn the surgeon of this fact. The second occasion on which artificial respiration should be interrupted is during the insertion of a needle into the heart. Inflation of the lung at the wrong time may result in laceration of the pleura or puncture of the lung.

8. *Inflation of the stomach.* As already mentioned, the stomach is likely to be inflated during some kinds of artificial respiration. It may be deflated from time to time during the resuscitative procedure by pressure on the epigastrium. At the end of the resuscitative efforts, whether the patient has recovered or been pronounced dead, the stomach should be deflated if it appears to be distended. This may require the insertion of a gastric tube. If the patient

is alive, the distended stomach may hamper respiration and circulation. If the patient is dead, the pathologist performing the autopsy may be misled into a diagnosis of acute dilation of the stomach if it has not been deflated.

9. *Duration of resuscitative efforts.* If there was no undue delay in instituting artificial circulation and if there is no added cause of anoxia, the resuscitative efforts may be continued for at least an hour before hope is abandoned.

SEQUELAE OF PROLONGED CARDIAC ARREST

Cardiac arrest is not in itself the cause of death or of subsequent pathologic conditions. It is only a functional disturbance. It is the resulting anoxia that causes damage, particularly to the nervous system where the damage rapidly reaches an irreversible degree. If this damage is sufficiently extensive, resuscitative measures will fail completely. Unfortunately, various degrees of damage resulting in permanent neurologic changes may occur. In many cases, cardiac and respiratory activity may be restored temporarily only to fail hours or days later. Hyperpyrexia may develop. In many other cases the patient may live for an indefinite period but with neurologic damage as manifest by dementia, spastic paraplegia, blindness, etc. Weinberger and co-workers,[11] working on cats, clamped the pulmonary artery for periods ranging from two minutes to ten minutes and fifteen seconds and analyzed the amount of damage resulting. In these experiments, arrest of the circulation for three minutes and ten seconds or less resulted in no neurologic disturbances. When the period was extended to three minutes and 25 seconds, changes in behavior and psychic functions occurred. After six minutes of circulatory arrest, vision and sensation were permanently impaired. After seven minutes and 35 seconds, there were permanent dementia, blindness, sensory and auditory defects, motor and postural defects and reflex abnormalities. After eight minutes and 45 seconds or longer, life could not be restored for more than a few hours. The human brain is probably more susceptible to anoxia than is that of cats.

In cases in which death occurs within a few hours after restoration of cardiac activity, there is usually pulmonary damage resulting in pulmonary edema.

INCIDENCE

It is impossible to estimate the actual incidence of cardiac arrest during anesthesia. There are many cases in which absence of pulse and blood pressure and respiration and other signs point to this diagnosis but in which the patient recovers promptly during the first minute or so of treatment. Barber and Madden[4] stated in 1945 that they had been able to collect from the literature reports of a total of 143 cases of "cardiac massage," with complete recovery in 48 cases (33 per cent). Many more cases must have occurred which are not in the literature.

At the Research and Educational Hospitals from September 1937 until May 1947, there were nine cases in which manual artificial circulation was carried out following sudden cessation of cardiac activity. One of the patients had a large pulmonary embolus and could not have recovered. Of the eight remaining, two made complete recoveries and two recovered temporarily but died, one in two hours and the other in 69 hours. During the same period there were eight other cases in which the patient died but in which radical measures were not tried. In several of those cases death was caused by neurologic disturbance.

The following cases are illustrative of certain features previously described.

A three-year-old boy who had been born with amputation of both thighs and was scheduled for reamputation of one thigh was anesthetized by open drop technique with ethyl chloride and ether. The ethyl chloride was discontinued early in the induction. A tourniquet was applied to the thigh prior to the operation. Thirty minutes after the operation started, the child's condition appeared to be good. The tourniquet was removed and the patient immediately became pale and pulseless and did not breathe. The anesthetist did not institute artificial respiration or other resuscitative measures and two or more minutes elapsed before another anesthetist who was called in lowered the patient's head and instituted mouth-to-mouth breathing. When there was no improvement, the orthopedic resident was asked to perform "cardiac massage." An abdominal incision was made and the cardiac massage was begun subdiaphragmatically. (In this case it appeared that the surgeon rubbed the heart in the manner of a masseur and did not institute efficient manual artificial circulation.) A few cardiac beats occurred but the action did not persist. Epinephrine, 0.5 cc., was injected into the right auricle. Spontaneous cardiac activity was restored, and spontaneous respirations followed. At first they were gasping but gradually they improved. Probably at least ten minutes had elapsed from the time of cardiac arrest until efficient circulation was restored. The abdomen was closed and the orthopedic operation completed. The patient was returned to bed and put in an oxygen tent. Twitching of the eyes, face and neck and hands was observed and pulmonary edema developed. The patient died two hours after the end of the operation. At autopsy, atelectasis of the right lung and congestion of the left, secondary to the pulmonary edema, were noted. A small incision in the stomach which had not been evident to the surgeon was observed. This had no bearing on the patient's death.

This case illustrates the importance of instituting effective treatment early. If artificial respiration had been started immediately, and efficient manual artificial circulation instituted within three minutes, the cerebral and pulmonary damage due to anoxia would probably not have occurred and restoration of cardiac activity might have restored the child to a healthy condition. The misleading implication of the term "cardiac massage" is illustrated, as is the importance of care not to damage the stomach in such procedures.

The patient was a 51-year-old obese female with cholecystitis and obstructive jaundice. There was no record of cardiac disturbance. Before anesthesia the blood pressure was 120 mm. of mercury systolic and 80 mm. diastolic. The pulse rate was 84. Pontocaine, 16 mg., was given intraspinally and anesthesia reached the fourth thoracic seg-

ment. Neosynephrine, 0.5 cc., then was given. Before the start of the operation, the blood pressure was 90 mm. of mercury systolic and 50 diastolic. Ten minutes after the beginning of the operation, just after the gallbladder lift had been raised and while the surgeon was palpating above the liver, the blood pressure could not be obtained, the pulse could not be felt and respirations ceased. Artificial respiration was started immediately. The surgeon palpated the heart and could detect no activity. Manual artificial circulation was instituted immediately by the subdiaphragmatic route and cardiac action returned very quickly. Following this, 1 cc. of epinephrine in 1:1,000 solution was injected into the heart. Spontaneous respirations were resumed. The whole episode probably lasted about two minutes. Following it the blood pressure rose to 200 mm. of mercury systolic and 140 mm. diastolic, then in the course of 20 minutes gradually decreased to 80 mm. systolic and 50 mm. diastolic. The stomach, which had been inflated during the artificial respiration, was deflated by insertion of a gastric tube. The remainder of the operation was uneventful. At the end of the operation the patient was awake and responsive and there was no evidence of damage. Oxygen therapy was given and recovery was satisfactory, although it was complicated by some consolidation of the upper lobe of the right lung.

This case illustrates the desirable result which may be obtained when artificial circulation is instituted promptly. The fact that an abdominal operation was in progress contributed to the speed with which this treatment was started. The injection of epinephrine was unnecessary and therefore injudicious. The cause of the arrest was probably reflex due to the surgical manipulation above the liver. That it occurred during spinal anesthesia is of interest.

A 17-year-old girl with mediastinal tumor was otherwise in good physical condition. The preoperative blood pressure was 120 mm. of mercury systolic and 55 mm. diastolic, and the pulse rate was 88. The patient was anesthetized with cyclopropane and intubated with an orotracheal tube with a cuff. Anesthesia was maintained in the low second plane. Controlled respirations were started 12 minutes after the operation started. The left pleural cavity was opened and the surgeon proceeded with the dissection of the mediastinal tumor. A blood transfusion was started 50 minutes after the beginning of the operation. An hour and 15 minutes after the start of the operation, while the surgeon was working in the left hilar region, the temporal pulse suddenly disappeared and the blood pressure could not be obtained. About 30 seconds later the surgeon was asked to examine the heart which was hidden by packs and a retractor. It was found to be in a state of standstill. Manual artificial circulation was immediately started, artificial respiration having been carried on during the entire time. About two minutes later, spontaneous cardiac activity was resumed, the heart rate being 104. Controlled respirations were continued and the operation completed 90 minutes later. Throughout this period, the pulse and blood pressure could not be obtained but the color of the blood was good and cardiac action could be observed. No addition of the anesthetic agent was necessary. There was some difficulty in administering fluids rapidly. The pulse and blood pressure were not obtainable until an hour after completion of the operation. At that time the pulse rate was 150 and the systolic blood pressure 80 mm. of mercury. The pulse rate rose as high as 200 but later returned to 130. The blood pressure slowly rose to 90 mm. of mercury systolic and 70 mm. diastolic. Postoperatively the temperature ranged from 101° to 104° F. On the third day tension pneumothorax was noted and several hundred cubic centimeters of fluid and air were removed. There were no signs of neurologic damage and the patient left the hospital in good condition.

In this case the cardiac arrest was probably due to reflex stimulation in the region of the hilus of the lung. The local use of procaine in this area or the intravenous injection of procaine or the administration of a large dose of atropine might have prevented the cardiac arrest. Prompt initiation of the artificial circulation resulted in complete recovery. When cardiac arrest is suspected, the anesthetist should not hesitate to interrupt the surgeon and call for his cooperation in making the diagnosis and in instituting treatment.

A 59-year-old woman with left hemiparesis as a result of a previous cerebral accident was operated upon for repair of evisceration four days after colostomy. Anesthesia was induced with cyclopropane with the canister out. Three minutes or less after the beginning of anesthesia the respirations became inadequate, the color was poor, and the pulse feeble. The anesthetic agent was stopped and pure oxygen was administered. A minute later neither blood pressure nor pulse was obtainable and respirations ceased. An endotracheal tube was inserted and artificial respiration was instituted immediately. The surgeon was notified of the seriousness of the situation and after three minutes of repeated urging he palpated the heart from below the diaphragm and reported no pulsation. Manual artificial circulation was then instituted. In 20 seconds a few weak beats were felt and five minutes later the heart was beating regularly at 120 beats per minute. Neosynephrine, 3 mg., was then given intramuscularly. Spontaneous respiration began 10 minutes after resumption of spontaneous cardiac activity. Oxygen was administered while the wound was being closed. When the patient left the operating room the blood pressure was 80 mm. of mercury systolic and 40 mm. diastolic, and the pulse rate was 120. The endotracheal tube was left in place and oxygen was continued on the ward. The patient died 69 hours postoperatively without having regained consciousness.

The previously existing brain damage probably made the nervous tissue more susceptible to anoxia, thus accounting for the fatal outcome in spite of the relatively early institution of manual artificial circulation. This case illustrates well the need for complete cooperation among the members of the operating room team and for a course of action based on a plan previously discussed.

CIRCULATORY COLLAPSE

There are many cases in which sudden circulatory collapse becomes apparent. It frequently occurs during rapid induction of general anesthesia. If neglected, it can go on to a more serious or even fatal outcome, whereas prompt initiation of artificial respiration and lowering the head results in prompt recovery. Whether any cases of circulatory collapse can truly be classified as cardiac arrest is uncertain, but undoubtedly many would rapidly fall into that classification if treatment were delayed.

A six-month-old girl was scheduled for lens extraction. Anesthesia was started with ethyl chloride by the open drop technique. Probably the ethyl chloride was allowed to flow

too freely and too long. About the time that the patient was in low second stage, ether was started but a little more ethyl chloride was added with it. Excess mucus developed. Obstruction, with little effort to breathe, followed. Respiration ceased, the pulse was not palpable, the heart beat was neither palpable nor audible, and there was pronounced prolongation of the capillary refill time. To all appearances the heart was in complete arrest. A few efforts to squeeze the chest and produce artificial respiration were ineffective. The child was turned for a brief period to the prone position to drain mucus from the mouth. An airway was inserted and mouth-to-mouth repiration was started. Spontaneous respirations were resumed after a few inflations and evidences of adequate circulation returned almost immediately. During the mouth-to-mouth respiration it was noted that considerable air was being blown into the stomach. This was expelled once by pressure on the epigastrium but the stomach became distended again; and after the child resumed normal respirations, the air could not be expelled in the same way. It was released through a Levine tube passed into the stomach. Anesthesia was continued for some time with ether, and was uneventful. The operation was cancelled not because of the circulatory collapse but because the surgical preparation had not been adequate. The child was anesthetized on a subsequent occasion without untoward effect.

In this case the circulatory collapse was probably due to some direct depressant effect of ethyl chloride on the myocardium. In such cases it appears that further anesthesia with another agent and continuance of the operation is not contraindicated because the episode does not necessarily indicate any inherent circulatory weakness.

An obese 61-year-old male patient was to have gastric resection for carcinoma. Edema of the ankles and pulmonary emphysema were noted preoperatively. The blood pressure was 130 mm. of mercury systolic and 80 mm. diastolic. Anesthesia was begun with cyclopropane by the closed technique. Orotracheal intubation was done with some difficulty, after which a canister was inserted. A few minutes after intubation the patient's pulse and blood pressure were unobtainable and respirations ceased. The lungs were inflated several times by pressure on the bag and almost immediately spontaneous respirations were resumed, the pulse became palpable at a rate of 70 and the blood pressure was 120 mm. of mercury systolic and 80 diastolic. At this time ether was started and cyclopropane gradually eliminated. The blood pressure rose to 160 mm. systolic and 90 diastolic, and the pulse rate to 108. Throughout the next three hours there was a gradual fall in blood pressure to 65 mm. systolic and 50 diastolic and a gradual slowing of the pulse to 56. No anesthetic agent was added for the last hour of anesthesia, and during the four and one-half hours of the operation the patient received 800 cc. of saline solution and 1,400 cc. of blood. Just as the last suture was being put in, the anesthesia was discontinued and a catheter was inserted through the endotracheal tube to aspirate secretions. The patient became cyanotic and respirations ceased. Artificial respiration with oxygen was started. The blood pressure and pulse could not be obtained. No radical procedures were instituted; and when the circulation did not return, the patient was pronounced dead.

At autopsy, extreme fatty infiltration of the heart was noted. The auricles particularly were almost replaced by fatty tissue. There was pronounced atherosclerosis of the coronary arteries. Partial atelectasis of the left lung was present; it was probably a terminal development, unrelated to the circulatory failure.

This case illustrates several interesting points. The anesthetists did not regard the initial circulatory collapse as an ominous sign and did not call it to the attention of the surgeon, who would have been willing to cancel or curtail the operative procedure. As the patient was obese, fatty infiltration of the myocardium might have been suspected and the emphysema might have been considered as a contraindication for anesthesia and operation. In such a case the early circulatory collapse should have been taken as a warning that the patient could not tolerate much trauma.

Circulatory collapse is a dangerous complication and may lead directly to death. Once the acute episode has been relieved, evaluation of its significance depends on various circumstances. If the patient is young and healthy and the episode has occurred during induction with an agent which may directly depress the heart, such as ethyl chloride, it may be assumed that it does not signify serious circulatory disease, and it is usually justifiable to proceed with the scheduled operation. Conversely, if the patient is old, obese, debilitated or has known cardiac disease, and if the agent was one which normally does not depress the heart, such as ether, circulatory collapse must be assumed to be ominous of serious impairment of the circulatory mechanism. The operation should be cancelled unless it is imperative for the patient's welfare. If it must be done, a minimal procedure should be selected; and, if possible, it should be postponed to a later date.

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The Use of Banthine in the Treatment of Digestive Disturbances

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SUMMARY

Banthine® was used in the treatment of patients with various diseases, organic and functional, of the gastrointestinal tract. Good response was obtained in a high proportion of cases of duodenal, stomal and gastric ulcer, and of hypertrophic gastritis. In some instances, patients who did not have good response at first were relieved later when the size of doses and the dosage schedule were adjusted to fit their particular needs.

Some patients "felt so well" during Banthine therapy that they departed from prescribed diet and violated injunctions against use of alcohol and tobacco, and symptoms recurred.

Nine patients with history of recurrent bouts of pain from ulcer for several years took small doses of Banthine constantly, or occasionally at times of stress, as a prophylactic measure after the symptoms were relieved by therapeutic doses. None of them had recurrence while following the prophylactic regimen.

In most of the cases of peptic ulcer in which the response was recorded as "poor," it was because distressing side-effects dictated discontinuance of the drug. Several elderly male patients had severe urinary retention. Paralytic ileus developed postoperatively in one patient who was receiving Banthine. Less severe side reactions—dry mouth, blurring of vision, urinary slowing—were for the most part transient.

Few patients with functional indigestion, chronic non-specific colitis or regional enteritis were relieved. Most of the patients with functional indigestion reported exacerbation of symptoms when Banthine was given. This was believed to be based on emotional reaction to the hypomotility induced by the drug.

SINCE its introduction to the medical profession two years ago, the newly described quaternary ammonium compound, Banthine® (B-di-ethyl-amino-ethyl xanthene-9-carboxylate methobromide) has been widely employed in the therapy of peptic ulcer as well as in other digestive disturbances in which it is believed that a drug with anticholinergic properties might be of therapeutic value.[4, 5, 6] The therapeutic value of Banthine is apparently due to its atropine-like effect in blocking postganglionic parasympathetic endings in the gastrointestinal tract.[3, 7] In man, Banthine is known to have a definite depressing effect on gastrointestinal motility[1, 4, 5, 6] and on the volume of gastric acid, although the degree of acidity is not greatly influenced.[1, 3, 4, 6, 7] It does not consistently block gastric acid secretion in man after insulin hypoglycemia[6, 7] but the drug does suppress the gastric secretory response to histamine.[3, 7] One striking effect of Banthine therapy is that frequently the pain of ulcer is relieved within a short time after administration of the drug has been started.[1, 4] The mechanism for this relief of abdominal pain is not clearly understood.

There are certain side effects of Banthine therapy which are quite disturbing to some patients when they are first given the drug. Although there are individual variations in the type and degree of the reactions, the most annnoying to the patient include dry mouth, blurred vision and, in males, urinary suppression. The latter reaction is noted primarily in older males with prostatic hypertrophy and it may be so pronounced that Banthine therapy must be discontinued. Certain psychic reactions have also been reported,[2] and a small group of patients has been seen in which Banthine therapy actually aggravates preexisting psychogenic digestive disturbances. This latter group will be discussed in this report. However, in general side effects subside spontaneously after 48 to 72 hours of treatment.

MATERIAL AND METHOD

The majority of the patients observed in this study were treated either on the gastrointestinal ward at the Wadsworth General Hospital or in the out-patient gastrointestinal clinic at the Cedars of Lebanon Hospital. In addition to these two sources of clinical material, certain patients treated privately, some by the author and others by two colleagues, have been included. The study includes patients

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from many social, economic and racial groups with illnesses varying greatly in nature and severity.

Unfortunately in a study of this sort it is impossible to establish rigid controls to evaluate the results of therapy. This is owing to the very nature of the illnesses treated, largely psychosomatic in character. Patients with psychosomatic disease will respond well to new medical regimens simply through suggestion. In many of the cases there are no good objective methods for determining improvement. In the case of peptic ulcer, it is possible to repeat the x-ray examinations of the stomach and duodenum at various time intervals to determine, roughly, healing by x-ray criteria. However, in busy hospital and clinic services this is not always feasible. In patients with spastic colon, functional indigestion and similar disturbances of the normal condition of the bowel there are no adequately objective methods for evaluating the degree of illness or the degree of response to therapy. Therefore, in this study each patient was his own control. The patients were observed at frequent intervals and attempts were made to obtain from them accurate descriptions of their subjective response to therapy; and, wherever it was possible, a statement was obtained from the patient comparing his response to Banthine with his response to previously prescribed medical regimens for the same disturbance.

In some cases two additional means of gauging the response of the patient to Banthine therapy were employed. The first of these involved starting a patient with a new untreated functional digestive disturbance on one of the older established medical regimens for a short time. After the patient manifested some subjective response to the first regimen this was stopped and Banthine therapy was initiated. A second method involved the administration of Banthine placebos. Patients did not respond in any way to placebo therapy. This seems to rule out pure suggestion as an important element in this study.

Although some of the patients in this series were observed for only short periods of treatment with Banthine, others, especially those with peptic ulcer, had been taking the drug for about ten months at the time of report.

Patients with various disturbances of the gastrointestinal tract were treated. The largest single group of patients consisted of those with peptic ulcer. The three types of benign peptic ulcer treated are considered together since the underlying pathologic changes in each type are essentially similar. The next largest group consisted of patients with indigestion, gas, nausea, spastic colon and other vague gastrointestinal complaints of nervous origin.

Because of the nature of their response to Banthine therapy, patients with chronic, non-specific ulcerative colitis and regional enteritis were listed separately. Patients with symptomatic chronic hypertrophic gastritis were considered with the peptic ulcer group. Such patients have gastric hyperacidity and hypermotility similar to that observed with peptic ulcer, and often they have distress of a similar type.

A small group of patients in this series was listed as having "other diseases," including sprue syndrome, dumping syndrome, biliary dyskinesia, chronic pancreatitis, and esophageal hiatal hernia. In this group there were not enough patients with any one diagnosis to permit adequate evaluation of therapy, but it was felt that certain comments could be made about the response of these patients to Banthine.

In expressing the results of Banthine therapy three grades of response were tabulated. A "good" response implies that objectively and subjectively Banthine therapy was highly satisfactory. "Fair" response indicates that it was felt that the patient obtained symptomatic relief from the drug but that the relief was no greater than was obtained by other regimens or that the results fell short of being actually ideal. Classified as "poor" response was any in which symptoms were aggravated by the drug or the drug had to be discontinued because of disturbing side effects. Also when untoward side effects of a psychogenic nature occurred, the response was considered "poor."

RESULTS

Peptic Ulcer

In the small group of patients with gastric ulcer, the response is either very satisfactory or quite poor (Table 1). Both of the patients who had poor response had intractable pain. One of the patients in addition was highly nervous and this nervousness was increased during the time that he was receiving Banthine. Of the three patients who responded well to Banthine, two eventually had gastric resection because of unsatisfactory x-ray evidence of healing of the lesions. In both cases, the ulcers were benign.

All of the patients with stomal ulcer became asymptomatic while they were receiving Banthine. Only one had a recurrence of trouble. Bleeding, without pain, developed and gastroenterostomy was carried out.

The majority of patients with duodenal ulcer responded well to Banthine therapy. In the "good" and "fair" response groups, however, not all the patients could be given symptomatic relief by Banthine alone. In all cases, patients with ulcer were directed to follow bland "ulcer" diets with between-meal feedings of milk or antacid substances. The use of alcohol and tobacco was forbidden. Patient cooperation in general was good. Sedation was given to patients who, although responding well to Ban-

TABLE 1.—*Results of Banthine Therapy in the Treatment of Disease of the Digestive Tract*

Diagnosis	No. of Cases	Results		
		Good	Fair	Poor
Peptic ulcer				
Duodenal	65	44	7	14
Stomal	7	5	2	....
Gastric	5	3	....	2
Hypertrophic gastritis	7	7	....	....
Functional indigestion	23	1	2	20
Chronic non-specific colitis and regional enteritis	7	....	1	6
Others	11	....	6	5

thine therapy, manifested extraordinary nervous irritability, and to patients who were being confronted with situations felt to be too disturbing to them. There was a tendency among patients who obtained good symptomatic relief on Banthine therapy to become dependent on Banthine for control of pain. In the earlier phases of this study, it was discovered that patients "felt so well" that they liberalized their diets or resumed the use of alcohol and tobacco without the physician's approval. In some of them, complications of ulcer developed as a result. Two patients had bleeding during the period of Banthine therapy, and in two others there was no evidence of healing noted in x-ray studies after six weeks and two months.

Patients who responded favorably to Banthine therapy soon became entirely free of abdominal pain and tenderness on palpation. This complete relief of distress usually occurred after about three weeks of treatment. It was observed that in some cases the original dose of Banthine then could be reduced and the diet liberalized without recurrence. In some instances, it was also possible to reduce the dose of sedative and antacid preparations. However, it was essential to consider each patient individually in readjusting diet and medication.

In the group with good results there were some patients who initially did poorly on Banthine. It was found that some of these patients were not receiving a sufficiently large dose of the drug. Whereas most adult male patients of average weight and height obtained symptomatic relief from the established dose of 100 mg. orally every six hours, some patients required larger amounts and some needed it oftener than every six hours. The dose and time interval were determined by how long the patient remained free of pain after Banthine was given and by the degree of freedom from pain obtained by the amount of Banthine given. Many female patients as well as males of small stature required smaller amounts of Banthine to control symptoms. In several cases, recurrence of distress developed while the patient was receiving Banthine therapy. In general this was controlled by increasing the dose of Banthine.

Fourteen of the patients with "good" response to Banthine therapy either took the drug constantly in small doses after symptoms were relieved or occasionally as a prophylactic measure at times of physical or emotional stress or when other illness developed. All of these patients were known to be susceptible to reactivation of ulcer distress; nine of them had had two or three recurrences annually for several years. None of them had a recurrence of distress while following the prophylatic regimen.

Striking analgesic effect of Banthine was observed in three patients who had severe pain extending into the back, suggestive of posterior penetration. They were relieved promptly by Banthine.

Most of the "poor" responses to Banthine therapy were not the result of failure of the drug to relieve symptoms of ulcer. In several cases Banthine had to be discontinued because of troublesome side effects (Table 2). Pronounced urinary retention developed in male patients in the older age group. Several of the patients in this group had, in addition to ulcer symptoms, other complaints of a functional nature. These were aggravated when Banthine was given, probably because of emotional instability. One instance of failure of Banthine therapy illustrates well the need for careful adjustment of the dosage of the drug. The patient was a 38-year-old woman who weighed 95 pounds. Several days after a major pelvic operation and while the patient was still in the hospital, a recurrence of ulcer distress developed. Banthine was given, 100 mg. every six hours. After 36 hours of Banthine therapy, pronounced abdominal distention, nausea, and vomiting developed and peristaltic sounds were absent. Ileus subsided when Banthine therapy was discontinued and intestinal intubation was carried out for a 24-hour period. In no case was Banthine therapy employed in patients with clinical evidence of pyloric obstruction, as it was felt that the hypomotility produced by Banthine would only aggravate the condition.

TABLE 2.—*Complications During Banthine Therapy*

Complication	Number
PEPTIC ULCER SERIES	
Hemorrhage	1
Urinary retention	3
Ileus	1
Central effect (excitement, depression)	6
Psychalgias (vague pains)	1
Excessive dry mouth	3
NON-ULCER SERIES	
Distention, gas	10
Symptoms aggravated	17
Central effect	2
Ileus	2
Excessive dry mouth	2

Chronic hypertrophic gastritis resembles peptic ulcer in a number of the clinical aspects. It is a functional disturbance of gastric secretion and motility, the cause of which is not known. However, it may be aggravated by emotional stress, dietary indiscretions or systemic infection. The diagnosis of this disturbance is based on gastroscopic observation. Banthine therapy often relieves the distress of this form of gastritis, but in the few cases in which gastroscopic examinations were carried out during the course of treatment little or no change in the state of the gastric mucosa was noted. It is important in treating patients with this disease to restrict the diet and the use of alcohol and tobacco. Sedation is employed wherever indicated.

Functional Indigestion and Spastic Colon

Patients with functional indigestion and spastic colon are for the most part far more unstable emotionally than are patients with ulcer. They are in general hypochondriacal, anxious, and fearful of cancer. Many have consulted innumerable physicians and received countless therapeutic regimens without relief. It was therefore not surprising to observe the uniformly poor response of such patients

to Banthine therapy. In nearly every case the symptoms were aggravated when Banthine was given; the patients had more gas, more nausea or more of whatever they complained of. It is felt that the poor response reflected the patients' interpretation of the diminution of gastrointestinal tract motility produced by Banthine.

Chronic Non-Specific Ulcerative Colitis and Regional Enteritis

In patients with chronic ulcerative colitis or regional enteritis, Banthine uniformly produced a striking degree of intestinal hypomotility, resulting in several instances in abdominal distention of a marked degree with diminution or even absence of peristaltic sounds. In all but one patient these reactions were so pronounced that Banthine therapy was discontinued. The patient who continued to receive the drug had mild ulcerative colitis limited to the sigmoid, and Banthine reduced the frequency of defecation and relieved the pain of the disease. In this group of patients reduction of the dose of Banthine in an effort to avoid production of ileus resulted in no apparent effect on bowel motility. The results of Banthine therapy in the small group of patients with these disorders as well as in spastic colon were similar in general to those reported by Kern and co-workers.[5]

Other Diseases

In the group of patients with "other diseases" of the gastrointestinal tract (Table 1) there were not enough with any one disease to permit drawing conclusions. However, the results of Banthine therapy in hiatal hernia suggest the drug may be of value in the treatment of this condition. One of the patients with hiatal hernia, who had not been satisfactorily relieved by other therapeutic regimens, began taking 50 mg. of Banthine with every meal when the drug first became available and was completely asymptomatic at the time of this report.

DISCUSSION

Although there is ample experimental evidence that Banthine will reduce motility throughout the gastrointestinal tract, the present study as well as previously published reports[4, 5, 6] indicates that, clinically, Banthine has its greatest application in diseases of the stomach and duodenum. Here, if used in conjunction with proper diet and at times sedatives and antacid preparations, it seems to be far more effective than any other anticholinergic preparation.

To date there is no complete explanation for the failure of Banthine to suppress small intestinal and colonic hypermotility more consistently. Kern and co-workers[5] noted that the drug will antagonize experimentally produced bowel hypermotility in the laboratory, but it will not control the hypermotility of emotional stress to the same degree. This would explain, at least in part, the failures of Banthine therapy that have been reported.

Certain conditions not only do not respond to Banthine therapy but may be aggravated by it. It is not unlikely that the Banthine-produced limitation of propulsive power proximal to a segment of bowel narrowed by the inflammatory process of regional enteritis or ulcerative colitis accounts for the ileus observed.

It is interesting to speculate on the reasons that Banthine therapy fails so completely in patients with functional indigestion and in emotionally unstable patients with peptic ulcer. In addition to the factors cited by Kern,[5] as was indicated in an earlier paragraph these patients are extremely introspective and overly aware of bowel activity. This is considered a major factor in the failures noted. The author pointed out in a previous report[2] that it may well be that Banthine, like certain other drugs (barbiturates, morphine, alcohol) is poorly tolerated by emotionally unstable persons. Certainly many patients who fit this description are intolerant of other medical regimens. Winklestein[8] raised the question that some sympathetic factor might contribute to some of these failures.

The matter of side reactions to Banthine therapy (Table 2) requires some consideration. The outstanding contraindication to Banthine therapy is benign prostatic hypertrophy, although some patients with enlarged prostate glands have been able to tolerate the drug if it is employed in gradually increasing doses. Theoretically glaucoma should be aggravated by Banthine therapy. To date no known instance of this has occurred. The one occurrence of paralytic ileus in a patient who received large doses of Banthine postoperatively points out the need for caution in Banthine therapy in this situation as well as the need for carefully adjusting the dosage of the drug to the weight of the patient. There has been no evidence that Banthine has any harmful cardiovascular effects. The more common side effects of dry mouth, blurred vision and urinary slowing usually subsided spontaneously after 48 to 72 hours of treatment.

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Treatment of Genito-Urinary Tuberculosis With Streptomycin and Synergistic Drugs

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SUMMARY

The use of newer drugs in the treatment of genito-urinary tuberculosis is usually auxiliary to accepted surgical and medical procedures. The treatment of choice is removal of the tuberculous focus by surgical methods whenever this can be achieved. Risk of tuberculous complications of surgical operation may be greatly reduced by the use of these drugs. There is also a significant place for such treatment when disease is too far advanced to permit surgical removal. Under these conditions, the principal result is one of palliation only in many circumstances. The drugs of choice at this time are a combination of streptomycin and para-aminosalicylic acid (PAS) and the treatment is frequently more prolonged than in the case of tuberculosis of other organs.

THE most significant recent practical developments in the field of antibacterial therapy of tuberculosis include: (1) The demonstration that para-aminosalicylic acid (PAS) is an effective and useful auxiliary remedy, and the widespread availability of this drug in a variety of acceptable formulations, (2) the repeated confirmation of the superior therapeutic value of streptomycin when combined with PAS, especially in delaying the development of bacilli which are resistant to either drug, (3) the apparent continued effectiveness of combination therapy for periods of time far in excess of that realized when streptomycin was used alone, (4) the possibility that streptomycin may at times retain some degree of beneficial action even after the tubercle bacilli appear to have become resistant to the drug as judged by laboratory tests, (5) the perfection of methods for parenteral administration of PAS in doses far in excess of those tolerated by the oral route, and with correspondingly enhanced therapeutic efficacy. All of these developments are of paramount significance in a disease so stubborn, so protracted, and so likely to recur as is tuberculosis of the genito-urinary tract.

For less than critical tuberculous infection, a therapeutic regimen employing PAS in doses of 12.0 gm. per day by mouth, combined with 1.0 gm. of streptomycin or dihydrostreptomycin injected intramuscularly two or three times per week, appears to be adequate to keep the disease process in check. The practical advantages of such a regimen, especially with regard to patients who are not confined to a hospital, is instantly obvious. Such a therapeutic program may be persisted in for long periods, often for many months, before the predominant bacteria appear to have become resistant either to streptomycin or to PAS. While no large series of patients with tuberculosis of the genito-urinary tract has been subjected to such therapy, the author has observed results in a sufficient number of cases to be convinced of genuine therapeutic accomplishments by this means. It is believed, however, that in certain acute and critical, rapidly progressive types of tuberculous infection, daily administration of streptomycin or dihydrostreptomycin may be necessary.

It is doubtful if there is any circumstance in which streptomycin should be employed without PAS in the treatment of tuberculosis, except when persisting severe allergic reaction to PAS makes administration of that drug impossible. The troublesome gastrointestinal irritation produced by PAS usually can be controlled by regulation of the dosage or by shifting to a different formulation, usually some form of the sodium salt combined into tablets or into coated and flavored granules. Fortunately drug tolerance often improves slowly and much depends upon the patient's zeal and fortitude and upon the physician's insistent encouragement and determination.

The protracted discussion concerning the relative toxicity of streptomycin and dihydrostreptomycin loses practical significance when the interrupted combined treatment regimen described earlier in this presentation is employed. When either drug is injected but twice or three times a week, toxic properties are rarely manifested. There is increasing evidence that daily streptomycin administration will produce vestibular damage of mild degree in a small but significant percentage of patients treated for many months. Also there are increasing numbers of reports of delayed damage to the auditory nerve when dihydrostreptomycin is employed in large doses for very long periods. These reports vary so widely that suspicion is growing that not all products labelled as dihydrostreptomycin were identical products, especially during the early months of the development of this drug. There is no convincing evidence that either streptomycin or dihydrostreptomycin possesses any superior therapeutic potency when the two are compared.

Antibacterial drugs other than the streptomycin drugs and PAS have not become established as suitable for the treatment of genito-urinary tract tuber-

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culosis. Derivatives of diaminodiphenylsulfone, of chaulmoogra oil, and of the thiosemicarbazone radical have been suggested but have not appeared to be equal to the PAS-streptomycin combination in treatment of this condition. Viomycin is being studied extensively at present but its present form offers certain disadvantages which make it appear to be an improbable successful contender in competition with PAS and streptomycin. However, it cannot be judged critically upon the meagre data available.

In nearly all instances those forms of genito-urinary tract tuberculosis which, before the advent of streptomycin and PAS, were regarded as necessitating surgical treatment are still so regarded. Furthermore, antibacterial therapy has strengthened the surgeon's approach to many forms of tuberculosis, has widened the range of application of surgical treatment, and has been at least of great palliative value in many circumstances in which, formerly, surgical treatment might have been regarded as a failure.

The availability of additional dynamic therapeutic procedures has made the diagnosis of genito-urinary tract tuberculosis of greater importance and has sharpened interest in the organs of the genito-urinary tract among physicians who care for tuberculous patients. Precise diagnosis and evaluation, such as can only be realized through thorough study by skilled urologists, has become essential whenever the tuberculous patient has urologic symptoms or whenever significant pyuria or microscopic hematuria is noted in routine urinalysis.

Destructive lesions of long-standing tuberculous infection frequently necessitate surgical extirpation when they are so localized as to be subject to removal at reasonable risk, and similar general rules apply whether the seat of the disease be in a lung or in a kidney. Mucous membrane implants, whether in the bladder, the larynx or the intestine, frequently respond most dramatically to adequate antibacterial therapy with relief of the distressing symptoms caused by such superficial lesions of sensitive mucosal surfaces. In the case of tuberculous cystitis the therapeutic objective frequently is palliation and the prevention or retardation of development of the contracted, low capacity, fibrotic bladder. This may be achieved frequently even when smouldering renal tuberculosis remains, and fortunately such renal infection may at times be compatible with many years of comfortable and productive life.

No discussion of genito-urinary tract tuberculosis is complete which does not stress the metastatic character of the disease and which does not urge the physician and the surgeon to search repeatedly for other foci of tuberculosis, and to employ all hygienic measures which may avoid further dissemination of the disease. Few patients with renal tuberculosis die of renal insufficiency; more commonly the fatal episode is due to tuberculosis elsewhere. Skeletal tuberculosis is peculiarly inclined to develop in association with renal tuberculosis.

The antibacterial drugs were recognized at once as offering real hope to patients with tuberculosis of the genito-urinary tract, but experience eventually produced many disappointments. These failures were usually attributable to the too brief period of effective action of streptomycin, because of the development of resistant bacilli, in so protracted a disease. With newer auxiliary drugs for treatment of streptomycin-resistant strains of bacilli, and with newer regimens of combined therapy which prolong the period of effective antibacterial activity, the future appears brighter than at any previous time.

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Correlation of Genito-Urinary and General Tuberculosis

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SUMMARY

Genito-urinary tuberculosis is considered to be a local manifestation of a generalized tuberculous infection which, for all practical purposes, has gained entrance to the body through the respiratory tract. Even though clinical or roentgenographic evidence of the pulmonary infection is found in only a small percentage of cases, the problem must be attacked as a whole.

Indolent or inactive disease in other parts of the body may become reactivated as the result of surgical intervention or severe complicating infection.

The importance of thorough general antituberculosis treatment in every case cannot be overemphasized.

AS tuberculosis is a generalized infection with focal manifestations most often in the lungs but not infrequently elsewhere in the body, evaluation of the problem of tuberculous lesions in the genito-urinary tract by physicians primarily interested in the medical aspects of pulmonary tuberculosis is quite in order. Directing treatment entirely at lesions at one site while ignoring the possibility of tuberculosis elsewhere may reduce a patient's chance of satisfactory recovery.

The reported incidence (Table 1) of genito-urinary tuberculosis depends upon whether the patients observed had active pulmonary tuberculosis, active extrapulmonary tuberculosis, or inactive or unapparent pulmonary tuberculosis. Statistics vary also according to the nature of the material studied —whether it is clinical or pathological, whether it is from general hospitals or from tuberculosis institutions. Much depends, too, upon how completely interested and efficient are the clinicians in searching for the presence of complications which may be symptomatically of minor significance.

MacLean[8] reported an incidence of 1 to 2 per cent observed in routine autopsies and of 5 per cent in cases in which there was active pulmonary tuberculosis. He cited reports noting up to 70 per cent incidence of genito-urinary lesions in cases in which there was active extrapulmonary tuberculosis. Bell[3] stated that "tuberculosis of the kidneys is one of the common diseases coming to the attention of urologists but is an infrequent cause of death." He noted renal tuberculosis, exclusive of the miliary form, in 0.22 per cent of autopsies; the incidence of all forms of tuberculosis in persons over one year of age in his material was 8.4 per cent. Miliary renal tuberculosis is observed very frequently at autopsy in cases in which death was caused by pulmonary tuberculosis; incidence of from 20 to 45 per cent has been reported by various observers. Ulcerative renal tuberculosis—that for which surgical treatment may be indicated—is a much less frequent complication; it has been observed at autopsy in from 3.5 to 7 per cent of cases in which the subjects died of pulmonary tuberculosis. In a study of the 1,168,000 patients who were discharged from or died at the Los Angeles County General Hospital between 1918 and 1948, Bogen and Butt[4] noted that in 743 cases (0.06 per cent) death was attributed to genito-urinary tuberculosis. Of some 50,000 patients with active pulmonary tuberculosis, 1.9 per cent had renal tuberculosis at the time of discharge from or death in the hospital; renal tuberculosis was the cause of death in 348 cases (0.7 per cent). In 6,000 of the 40,000 autopsies performed in the 30-year period, evidence of pulmonary and/or extrapulmonary tuberculosis was noted, and renal tuberculous lesions were observed macroscopically in 644 subjects—10.6 per cent of those in which tuberculosis was present. Macroscopic tuberculous lesions of the urinary tract were noted in 20 per cent of cases in which death was attributed to pulmonary tuberculosis. Tuberculosis of the urinary tract was observed in only 4.9 per cent of cases in which pulmonary tuberculosis was present but the patient had died of something else. There were only six cases in which tuberculous lesions were observed only in the genito-urinary tract.

Medlar,[10] in an analysis of postmortem examination of 5,424 male subjects over 16 years of age, at Bellevue Hospital from 1935 through 1944, noted that tuberculous lesions in the genito-urinary system were present in 3.1 per cent of the total number, in 4.5 per cent of the cases in which unhealed pulmonary tuberculous lesions were present but death was from other causes, and in 26 per cent of cases in which pulmonary tuberculosis was the cause of death.

Davenport and Greenleaf,[6] reviewing autopsy reports from Fitzsimons General Army Hospital on 500 consecutive cases in which pulmonary tuberculosis was the primary cause of death, noted that there was also renal involvement in 29.2 per cent of the subjects and genital involvement in 15 per cent. As the average age of patients at Fitzsimons is relatively low, the data might be indicative that the incidence of tuberculous infection of the genito-urinary tract in the younger age groups is higher than it is generally believed to be. Bell,[3] reporting on autopsy in

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TABLE 1.—*Reported Incidence of Genito-Urinary Tuberculosis Observed at Autopsy.*

	Incidence Per Cent Reported by					
	MACLEAN	MCKENNA	DAVENPORT	BOGEN	BELL	MEDLAR
In routine autopsy	2.0	.....	.....	1.6	0.22	3.1
In subjects with active pulmonary tuberculosis at death	5.0	5.0	.....	5.0	3.5	4.5
When death was caused by pulmonary tuberculosis	10.0	.....	44.0	20.0	.....	26.0
In subjects with active extrapulmonary tuberculosis at death	.....	30-70	.....	.....	.....	.....

133 cases of clinical renal tuberculosis, stated that in 21 instances there was no evidence of pulmonary disease, in 38 there were inactive or healed pulmonary lesions, and in 74 (56 per cent) active pulmonary disease was present. Bell also cited a number of reports by other investigators who, at autopsy, had noted active pulmonary tuberculous lesions in from 30 to 35 per cent of subjects with renal tuberculosis.

In the past the incidence of renal tuberculosis in children has been much lower than in adults because they so often have acute miliary infection with a mortality rate of some 80 per cent in the first two years of life. In the past five years, however, since the advent of streptomycin therapy, the mortality rate has been greatly reduced; and it may be that with the higher survival rate will come an increase in incidence of extrapulmonary tuberculosis in children. Pollock[11] noted renal tuberculosis at autopsy in 1.5 per cent of cases of patients who died on the pediatric tuberculosis service at Sea View Hospital, but in only four of 2,500 subjects examined postmortem on the general pediatric service. On the latter service, however, renal tuberculosis of the kind that is amenable to surgical treatment was proved in five of 312 cases in which the patients had chronic pyuria.

Infection with bovine tubercle bacilli, once the commonest infective organism, now rarely occurs in this country. This is attributed directly to the enforced routine tuberculin skin testing of cattle and the destruction of infected animals.

There are two main portals by which tubercle bacilli enter the body—the digestive tract and the respiratory tract. Tubercle bacilli usually focalize in the lungs and in tracheobronchial lymph nodes, regardless of the portal of entry; whether the respiratory or the digestive tract is the more common portal is still debatable. Less commonly, the bacilli enter through the eye, through an abrasion of the skin, or, in females, through the genital tract.

As Auerbach,[1,2] Thomas[13] and others have brought out, the most generally accepted postulation is that infection of the kidney is hematogenous, because multiple bilateral seeding is commonly observed, because healed foci often are present, and because of the initiation of ulcerative renal tuberculosis by focal rupture into a calyx or collecting tubule. These investigators have cited voluminous evidence to refute the possibility or to establish the extreme rarity of renal infection by way of primary infection from the anterior urethra, direct extension from a neighboring tuberculous process, lymphatic extension from a neighboring lymph node, or ascending infection from the genital organs.

Metastatic infection from pulmonary lesions to distant organs occurs after tubercle bacilli enter the blood stream, which may come about either by direct erosion of a tuberculous focus into a blood vessel, or by way of the lymph stream which may carry bacilli by way of the thoracic duct into the subclavian vein. Bacterial emboli may lodge in the smallest blood vessels in various organs and tissues but clinically manifest lesions do not always develop at the site. It is believed that the factors governing the chance of development of an active lesion are the number and the virulence of bacilli present, the site of the implantation, the presence or absence of local injury or other infection, and the individual's general resistance against tuberculosis. Resistance against such an invasion and attempts at healing may be manifest in any organ, but in some portions of the body these factors are less cogent than in others.

PHASES OF TUBERCULOUS MANIFESTATIONS

The various phases of the manifestations of tubercle bacilli in the human body have many times been likened to those of syphilis. The cycle of events may be described under four headings, dating from the time of invasion by the tubercle bacilli to the most advanced lesions of visceral caseocavernous tuberculosis.

1. The period of incubation — a latent period from the time of original implantation of tubercle bacilli to the appearance of a positive reaction to a skin test with tuberculin.

2. The period of invasion—the time in which the organisms reach the lymphoid system. This is generally a silent phase as far as clinical manifestations are concerned.

3. The period of visceral spread — the time in which, lymphoid resistance having been overcome, implantations of tubercle bacilli reach the various organs by way of the blood stream. The nature of the lesions produced in the tissues by tubercle bacilli depends upon the factors previously enumerated (number and virulence of the organisms, local and general tissue resistance, etc.). The lesions may be sparse or miliary, active or relatively quiescent. Should the original infection be massive, the second phase follows a rapid course and the metastatic foci may become fulminant and rapidly fatal. Should the period of invasion be resisted by the lymphoid sys-

tem, leakage of bacilli into the blood stream will be sparse and infrequent and the metastatic foci rare and slow to develop.

4. The period of advanced caseocavernous tuberculosis. This is the stage of active pulmonary tuberculosis (phthisis) characterized by extensive caseous or ulcerative lesions in the lungs.

As to renal tuberculosis, it would appear that the implantations of tubercle bacilli reach the kidney at a stage in the disease long before the fourth period in which there are gross lesions in the lungs. It is probably in the third stage of tuberculosis, the period of general infection when tubercle bacilli are escaping from the lymphatic system to the blood stream, that the earliest minute foci appear in the kidney. It is in this stage, after lymphatic resistance has been overcome and intermittent hematogenous dissemination of tubercle bacilli is taking place, that implantations occur in the renal cortex which give rise to tubercle bacilluria. As a rule, persons in whom this phenomenon occurs have very nearly, but not quite, overcome the tuberculous infection in its second stage of systemic invasion.

Pathologists, spearheaded by the meticulous work of Medlar over the past 30 years, have traced exactly what occurs when the body is invaded by tubercle bacilli. Save for variations caused by differences in histologic and anatomic structure, tuberculous lesions in the kidney do not differ from those in other organs and tissues of the body. As far as can be determined, the cells that participate in the defensive and reparative processes as regards tuberculous lesions are of the same type in all tissues and organs. The end product of the reparative process is a scar with no indication of the causative factor.

It is not uncommon for a great variety of tuberculous lesions to be present in a single kidney. Mononuclear tubercles, tuberculous abscesses, areas of caseation, scarred areas infiltrated with lymphocytes and with one to many giant cells present, and scars devoid of lymphocytic or mononuclear leukocytic infiltration have all been observed in one organ. From this it would appear that the patient had had, at intervals, showers of tubercle bacilli in the blood stream, and that these showers had been followed by the development of tuberculous lesions in the kidney. The pathologic processes observed in such organs represent, then, lesions of different age and severity, and the scars represent the healed stage in an area where the tubercle bacilli have been overcome. In light of these observations plus the fact that tubercle bacilluria is noted in about 10 per cent of the cases reported without clinical manifestations of renal involvement, it must be agreed that renal tuberculosis with bacilluria can exist without causing symptoms. Rosencrantz and Charnock,[12] in an investigation of 200 men with active pulmonary tuberculosis but with no complaints referable to the genito-urinary tract, noted that there were tubercle bacilli in the urine of 7 per cent of the patients, and that 18 per cent had tuberculosis of the genital tract without bacilluria. It is believed that bacilluria does not exist without ulcerative lesions in the kidney. These lesions are often microscopic and are frequently overlooked. On the other hand, it would seem that renal tuberculosis can exist without bacilluria, judging from the absence of inflammatory exudate and bacilli in the lumen of the tubules in many cases.

Medlar's conception of the pathogenesis of genito-urinary tuberculosis may be at variance with some clinical concepts, but his views must be respected inasmuch as they are based on extremely thorough pathological studies in which the existence of tuberculous disease without significant clinical symptoms was observed. It has been noted that microscopic tuberculous lesions can ulcerate into renal tubules, discharge bacilli into the urine, and then heal completely. Medlar expressed the belief that it is possible for the prostate gland to become infected at the time the urine is contaminated, which could account for the finding, at necropsy, of tuberculosis in the prostate gland of subjects with macroscopically normal kidneys. He said that it could not be assumed that renal lesions never had existed even though the only tuberculous lesions observed were in the genital organs. In Medlar's autopsy series, renal lesions were observed in twice as many subjects as were prostate lesions, and in three times as many as were lesions in other genital organs. Of the renal lesions, 64 per cent were miliary; and involvement of the genital organs in association with miliary renal disease was infrequent. Combined renal and genital tuberculosis was five times more common in subjects with necrotic foci than in those with miliary lesions. These observations suggest that in at least a high proportion of cases in which prostatic involvement occurs, it follows the development of renal lesions. The data also indicate that the prostate gland is the most often affected of the organs in the genital system.

INFECTION OF OTHER GENITAL ORGANS

Although there is general agreement that tuberculosis of the kidney is metastatic and blood-borne, there is no such agreement relative to tuberculous infection of the organs of the genital system, and especially with reference to the relationship of infection in one organ to infection of other organs of the system. Barney[7] expressed the belief that infection is blood-borne to the epididymis, and from there spreads by lymphatic channels to the seminal vesicles and the prostate gland. Young[7] took the view that the first focus in the genital system is in a seminal vesicle, whence the disease spreads to the prostate gland, and then, by lymphatic extension, to the epididymis. Borthwick[5] strongly supported Young's theory of central infection and centrifugal spread, although he took the view, as do many other investigators now, that infection is by bacilluria, reaching the prostate primarily, and that downward spread along the vas to the epididymis is via the lumen and not by lymphatic channels. In support of this view, Borthwick noted that in a very high proportion of all cases of tuberculosis of the genital tract tubercle bacilluria was present at some stage. Also he noted

palpable evidence of prostatic or vesicular involvement in 83 per cent of 237 cases of tuberculous epididymitis, an observation that appears to accord with Medlar's[10] report that in subjects in which tuberculous epididymal lesions were of macroscopic proportions, more than one—and frequently all—of the genital organs were tuberculous. A comparison of the incidence of epididymal tuberculosis with that of tuberculosis of the fallopian tube (recalling that the urinary and genital systems of the female are separated completely) suggests strongly that epididymal tuberculosis is related much more closely to the disease in other organs of the genito-urinary system than to a direct implantation from the blood stream: Tuberculosis of the fallopian tube occurs about as frequently in association with miliary as with necrotic renal lesions, whereas the incidence of epididymal tuberculosis is eight times greater in persons with necrotic or excavating renal lesions than it is in persons in whom the renal disease is miliary.

In the management of patients who have genito-urinary tuberculosis, it must be borne in mind that renal tuberculosis must be related to a primary focus of living bacilli elsewhere in the body. The primary lesion may have occurred in childhood or adolescence. As renal tuberculosis is the result of hematogenous dissemination of tubercle bacilli to the viscera, complete and systematic clinical, laboratory and radiological examinations must be carried out. The presence of extra-urogenital foci of tuberculous infection is particularly likely. If such foci are active, surgical intervention may increase the activity. If they are quiescent, they may remain so during surgical intervention or they may become reactivated, depending upon the virulence of the organisms and the powers of resistance of the patient. Surgeons and physicians managing the conservative treatment must cooperate closely, recognizing the importance of dealing with tuberculosis as a generalized infection. As has so often been emphasized, particularly by urologists who have worked closely with tuberculosis sanatoria, since urologic tuberculosis is chronic and slowly progressive, there rarely is need for rushing into a course of treatment before the condition of the entire genito-urinary tract is determined and attempt is made to locate the primary source of the infection.

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Indications for Surgical Treatment in Genito-Urinary Tuberculosis

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SUMMARY

Proper methods of surgical treatment effect arrest of localized tuberculosis in 90 per cent of cases, but as early and latent renal tuberculosis can be controlled in 50 per cent of cases by conservative treatment, careful deliberation as to choice of method of treatment is necessary in each case. In some circumstances, operation is definitely contraindicated. These observations apply also to tuberculosis elsewhere in the urogenital tract. When surgical treatment is carried out, careful preoperative and postoperative medical care is an important factor.

The primary site of urogenital tuberculosis is the kidney, from which organ the infection spreads to the ureter, the bladder and the prostate gland. The prostate gland is the initial site of invasion in the genital tract, extension to other genital structures following. This sequence of infection is an important consideration in determining the management of urogenital tuberculosis.

SURGICAL therapy for tuberculosis is a medical as well as a surgical problem, the surgeon being one member of the therapeutic team. Tuberculous lesions other than pulmonary are but manifestations of the constitutional disease; the primary lesion is always in the chest. The infection spreads from the lungs through the large lymphatic duct into the subclavian vein, into the general circulation, and thence to various organs and tissues. At times, when drainage becomes obstructed or when medical treatment is ineffective, an infected organ must be excised.

Once tuberculosis has spread from the chest, it is doubtful that it ever is completely eliminated, but it may be controlled; surgical treatment does not cure tuberculosis, but rather aids in obtaining the optimal clinical result. Frequently, surgical treatment can benefit tuberculous patients, provided their specific problems are considered.

General and local resistance against Mycobacterium tuberculosis can develop in the human organism, and an understanding of the mechanism by which it develops is essential to proper management, whether medical or surgical. The success of surgical treatment depends on careful selection of patients, proper timing of the operation, and long postoperative care. The important lesions—those that may cause death—must be attacked first. If there are active lesions in the lungs or elsewhere, operation should be postponed until they are arrested. Postoperative care must be continued until any residual infection or any lesions activated by the surgical manipulation become quiescent.

Renal Tuberculosis

In more than 50 per cent of cases of early and latent renal tuberculosis, arrest of the local lesion can be brought about by conservative treatment. Proper methods of surgical treatment effect ultimate arrest of localized tuberculosis in 90 per cent of cases. Patients recover more quickly if treated medically both before and after operation.

Nondestructive renal tuberculosis, even if unilateral, should not be treated by surgical intervention. Constitutional treatment should be instituted and the local lesion should be carefully observed in order that if a destructive process develops, it will be known immediately.

Unilateral destructive renal tuberculosis is an indication for nephrectomy provided (1) the other kidney is functionally sound and is free of tuberculous infection, (2) active local or general tuberculosis is not present, and (3) the general condition of the patient is such as to enable him to withstand an operative procedure of this magnitude.

In the case of a small destructive lesion of the kidney, the choice of surgical extirpation or watchful waiting frequently is difficult. Such lesions may involve only 1 per cent to 5 per cent of the tissue in an otherwise normal kidney. To sacrifice the entire organ because of a small destructive lesion, especially in view of the high incidence of bilateral renal tuberculosis, seems unjustifiable. If a patient is treated for constitutional tuberculosis, specific therapy for small destructive lesions may be postponed almost indefinitely. Treatment of the constitutional disease must be intensive and the progress of the local lesions must be noted regularly.

Treatment for bilateral renal involvement also requires deliberation. If there is complete renal destruction on one side, if the other kidney has a nondestructive lesion and good function, and if the patient's resistance against tuberculous manifestations elsewhere in the body is satisfactory, then nephrectomy is justifiable, provided surgical treatment is preceded and followed by general hygienic

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measures. If, on the other hand, the lesions are small on both sides, or small on one side and of moderate size on the other, surgical treatment should not be undertaken. The duration of life for patients with bilateral renal tuberculosis is determined to a large extent by the amount of residual well-functioning renal tissue; frequently it is substantial, so that two tuberculous kidneys provide greater reserve and a better prognosis than only one kidney. Constitutional treatment, heliotherapy, and the careful cooperation of the patient may prolong life for several years.

If the lesions in one kidney are progressive and the other kidney is functionally sound, nephrectomy should be done. However, unless there is an accompanying acute ureteral obstruction or hemorrhage, the patient should be treated conservatively until the exact character and extent of the local lesion are determined.

Before nephrectomy is considered[1,2,3] the following criteria should be established: evidence of considerable destruction and cavitation of the kidney; the presence of tubercle bacilli in the urine on repeated examination at intervals of considerable duration; the absence of tubercle bacilli in the urine from the opposite kidney on repeated examination; the failure of medical management of the type now employed in pulmonary tuberculosis—that is, proper sanitarium regimen and the administration of chemotherapeutic and antibiotic agents in suitable dosage.

Tuberculosis of the Ureter

Tuberculosis of the ureter always is secondary to renal tuberculosis. Indications for surgical treatment are similar to those for the kidney.

Tuberculosis of the Bladder

Surgical treatment for vesical tuberculosis consists in light fulguration of nonhealing vesical lesions after removal of the original focus in the kidney, and sometimes in diversion of the urinary stream without removal of the bladder. Antibiotic and chemotherapeutic agents frequently will control the symptoms, or the lesions themselves, so that resort to surgical procedure or even cautery is now less frequent than it was before the introduction of these agents.

Tuberculosis of the Genital Tract

The initial lesion of urogenital tuberculosis is located in the kidneys. Infection spreads to the ureters, the bladder, the prostate gland, the seminal vesicles, the vas deferens and the epididymis, at first by way of the urine. Later, spread of the tuberculous process is by direct extension along the vas from the prostate gland to the epididymis and through the ejaculatory duct to the seminal vesicles.

In the genital tract proper, the prostate gland is the initial site of tuberculous infection. Clinical research and examination of tissues removed at operation and postmortem examinations has convinced the author that prostatic tuberculous infection is derived from infected urine from a tuberculous kidney. From the prostate gland, extension of tuberculous infection is by way of the hollow tubes or ducts, as the lumen of the vas into the epididymis.

Destruction of prostatic tissue may result in excavations and scars sufficient to produce obstruction and interference with urination. Following control of the renal tuberculous lesions, transurethral prostatic resection occasionally is necessary.

Surgical treatment for tuberculosis of the vas and of the epididymis is less frequently employed since the advent of the chemotherapeutic agents and the antibiotics. The author has never found it necessary to excise the seminal vesicles or the entire prostatic gland because of tuberculous infection, and is of the belief that these lesions should be treated conservatively, especially in the presence of active tuberculous lesions in the kidney or the lungs. Even before the antibiotics and chemotherapy were introduced, the author observed cases in which active tuberculous lesions of the vas and the epididymis were arrested by such measures as continuous moist heat and, when necessary, drainage of infected suppurating areas adherent to the skin over the vas or the epididymis by needle puncture or a small incision. In cases in which nephrectomy was necessary, if conservative management was ineffective in retarding local lesions of the vas and the epididymis, surgical removal of these structures was carried out.

Another reason for avoiding surgical treatment for tuberculous infection of the epididymis and the vas is the hazard incurred to the testicular blood supply. A single main artery, with branches to the epididymis, the vas, and the testis constitutes the blood supply to these structures. The pattern of these branches varies so much that, in spite of careful dissection, the testicular branch can inadvertently be cut and tied, resulting in atrophy of the testis. This frequent complication encourages a conservative attitude and the use of the less hazardous medical regimen. Since tuberculous epididymitis is bilateral in 60 to 70 per cent of cases, the risk of complete loss of testicular function is an accompaniment of surgical treatment for tuberculosis of the epididymis.

Only infrequently has the author found it necessary to remove the testis. Occasionally some testicular tissue must be excised, but the testes have considerable resistance to tuberculous infection.

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Experiences With ACTH and Cortisone in Selected Dermatoses

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SUMMARY

Fifty patients with various kinds of skin diseases who were not adequately relieved by conventional therapy were treated with ACTH or cortisone given systemically.

Almost all patients with disseminated neurodermatitis had dramatic initial response, but in only about half the cases was improvement maintained when use of the drugs was discontinued.

It appeared that in other skin diseases, such as lupus erythematosus, scleroderma, psoriasis, dermatomyositis and pemphigus, while improvement may be noted for a time, relapse to the original state occurs after the treatment is stopped.

In four cases of chronic discoid lupus erythematosus, although some improvement was observed when steroid therapy was given, the histologic pattern of biopsy material taken from the lesions after treatment still was characteristic of the disease.

ADRENOCORTICOTROPIC hormone (ACTH) and cortisone were used systemically in the treatment of 50 selected patients with skin diseases. In most cases the dermatosis was recalcitrant to conventional therapy.

In the present report, *disseminated neurodermatitis* and *atopic dermatitis* are used as synonymous terms; and by *eczema*, as the term is used here, is meant dyshidrotic or asteatotic pruritic non-specific dermatosis characterized by erythematous papulovesicular eruption.

Of the 50 patients, 22 had atopic dermatitis, four chronic lupus erythematosus, four acrosclerotic scleroderma, eight "drug eruptions," two psoriasis, two pemphigus, two eczema, two pruritus due to systemic disease, one Kaposi's idiopathic multiple hemorrhagic sarcoma, one idiopathic urticaria, one urticaria due to food sensitivity, and one infectious eczematoid dermatitis.

Steroid therapy was not instituted until after sufficient trial of other methods had failed. All patients treated were observed for the initial eosinophil response to adrenal cortical stimulation or to cortisone, and the weight and blood pressure of all patients was recorded daily. If extended treatment was necessary, electrolyte studies were done at regular intervals.

Improvement was graded as slight, moderate, or great, and the grade was determined by the degree of reduction in the objective symptoms in the skin (such as erythema, lichenification, edema and scaling) and of decrease in the subjective symptoms such as burning and itching.

ACTH was given intramuscularly and cortisone intramuscularly and orally in daily divided doses. It was usual to give 100 to 120 mg. of ACTH per day for the first three or four days and then reduce the amount gradually to 40 to 60 mg. per day. The schedule for cortisone usually consisted of 300 mg., 200 mg., and 100 mg. on successive days and then 100 mg. per day until further gradual reduction was decided upon.

Atopic Dermatitis

Of the 22 patients with atopic dermatitis treated with ACTH or cortisone (Table 1), 13 had dramatic improvement, with reduction in the erythema, resolution of the weeping and lessening of the itching within 48 hours (Figure 1). Nine others improved appreciably in four to five days. Therapy was continued after clinical improvement at a maintenance dose with the idea that the longer the itch-scratch reflex was blocked, the longer the healing time and the less likelihood of relapse. At the time of this report 12 of the 22 patients had complete relapse. In seven cases there was continued improvement, but the longest follow-up was only five months. Two patients had initial improvement but did not return for further observation. One patient had partial relapse and at the time of report had remained in that condition for five months.

Drug Eruptions

Eight patients with "drug eruptions" were treated with ACTH or cortisone. Two patients who had eczematous eruption from gold therapy responded promptly to cortisone, and there was no relapse. One patient with blotchy erythema that had developed when Terramycin® was given systemically for infection of the urinary tract was given cortisone orally. The skin lesions cleared up immediately but recurred three times at the same sites. ACTH then was given and the skin cleared and remained clear. One case of exfoliative dermatitis in a man who had been given sulfamerazine for infection of the urinary tract was treated with cortisone by mouth. The dermatitis cleared rapidly and did not recur. Another patient with a morbilliform eruption due to mersalyl had dramatic response to cortisone given

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orally, and the skin remained clear. Three patients with acute urticaria owing to sensitivity to penicillin were treated. In two patients the results were very good, but in one the effect was equivocal.

Miscellaneous Dermatoses

Four patients with chronic discoid lupus erythematosus were treated with cortisone. The longest period of treatment was three and one-half months and the shortest was one month. All four patients previously had had adequate courses of gold and bismuth with no response. Three of the patients had moderate response and one a slight response to cortisone therapy, but in all cases there were relapses to the former state when treatment was discontinued.

Four patients with acrosclerosis received ACTH or cortisone. Three were not relieved. One had moderate improvement with softening and increased mobility of the skin. While the patient was undergoing steroid therapy, however, visceral scleroderma changes developed.

Cortisone was used in two cases of pemphigus vulgaris. One of the patients, a 54-year-old man seriously ill with acute fulminating pemphigus, had dramatic response, and six months after therapy still was free of lesions (Figure 2). The other patient had pemphigus foliaceus of several years' duration. There was slight response to cortisone, and immediate relapse when therapy was discontinued. ACTH was tried and the result was equally disappointing.

Two patients with dyshidrotic eczema involving the hands and arms and complicated by overtreatment had no response to adequate trial of steroid therapy. One was given cortisone by mouth for two weeks and the other received ACTH followed by a course of cortisone.

Cortisone was given orally in two cases of severe pruritus associated with systemic disease—Hodgkin's disease in one case and biliary cirrhosis with xanthomatosis in the other—and the pruritus in both cases was relieved but it recurred immediately when the hormone was discontinued or even when the dose was reduced. The skin xanthomata were not

TABLE 1.—*Disseminated Neurodermatitis (Atopic Dermatitis) Treated with ACTH and Cortisone*

	Age and Sex	Duration of Illness	ACTH	Cortisone	Length of Treatment (days)	Total Dose (mg.)	Initial Improvement	Follow-up
1.	14 mo. M	11 months	.....	syst.	7	400	great	Slight relapse followed by improvement. No follow-up.
2.	17 mo. F	14 months	.....	syst.	7	450	great	Great improvement. Followed for three months.
3.	14 yr. F	History of infantile eczema	.....	syst.	14	2000	great	Complete relapse.
4.	18 yr. M	Present attack 2 years. History of infantile eczema	.....	syst.	11	720	great	Complete relapse.
5.	21 yr. F	Recurrent since infancy	.....	syst.	12	1300	great	Complete relapse.
6.	23 yr. F	Recurrent since infancy	.....	syst.	14	1400	great	Great improvement. Followed for four months.
7.	23 yr. M	Present attack 6 months. History of infantile eczema	.....	oral	11	1200	great	Slight relapse followed by great improvement. Followed for two months.
8.	27 yr. F	6 months	.....	oral	28	3300	great	Slight relapse followed by great improvement. Followed for four months.
9.	29 yr. F	Recurrent 1 year	yes	.....	9	720	great	No follow-up. Patient did not return.
10.	30 yr. M	Recurrent since infancy	.....	syst.	12	1300	great	Complete relapse.
11.	30 yr. M	Recurrent since infancy	yes	.....	11	1000	great	Complete relapse.
12.	40 yr. M	Recurrent 15 years	.....	syst.	14	1200	moderate	Complete relapse.
13.	41 yr. M	2 months	yes	.....	11	600	great	Complete relapse.
14.	42 yr. M	2 month	.....	oral	21	3000	great	Slight relapse followed by moderate improvement. Followed for three months.
15.	52 yr. M	Recurrent 6 years	..... yes	syst.	5 5	700 500	moderate great	Complete relapse. .....
16.	54 yr. M	8 months	yes	.....	7	400	moderate	Continued improvement. Followed for two months.
17.	55 yr. F	1 year	yes	..... syst.	25 21	2000 2500	great	Relapse, but not complete. .....
18.	61 yr. M	4 months	yes	.....	9	550	moderate	Great improvement. Followed for five months.
19.	62 yr. M	Recurrent 6 years	yes	.....	14	1240	great	Complete relapse.
20.	64 yr. M	Recurrent 8 years	yes	.....	30	2025	great	Complete relapse.
21.	66 yr. M	Recurrent 4 years	yes	.....	9	575	great	Complete relapse.
22.	80 yr. M	6 months	.....	oral	7	900	great	Complete relapse.

affected and the depth of jaundice remained about the same.

One patient with generalized psoriasis without arthritis was given cortisone by mouth for one month with no improvement. Another, who had severe rheumatoid arthritis and psoriasis, had no cutaneous improvement after three months of cortisone therapy (100 mg. daily), but subsequently a course of ACTH was given and in two weeks of therapy improvement occurred in more than half of the lesions. A nine-year-old girl with sensitization dermatitis and secondary infection, involving the face, neck and extremities, that had developed after a plastic operation on the face, was given cortisone, and within 48 hours the lesions were almost cleared (Figure 3). Treatment was given for one week, and there was no relapse after three months.

One patient with chronic idiopathic urticaria, possibly psychogenic, became worse while ACTH therapy was being carried out, while another patient with the disease, which might have been caused by allergic sensitivity to a food, had immediate clearing and no recurrence.

In a case of Kaposi's multiple idiopathic hemorrhagic sarcoma, no improvement was noted after ten days of therapy with cortisone, and new lesions continued to develop.

DISCUSSION

It is interesting to consider the rationale for the use of ACTH and cortisone in certain dermatoses. Adrenocorticotropin used systemically and adrenal cortical extract and cortisone applied locally have effects on the skin of rats.[1, 12, 13] After prolonged treatment these effects consist of a thinning of the epidermis both in number of cells and in cell area in the prickle layer, reduction of collagen bundles with increased compactness of collagen, reduction in size of sebaceous glands and hair follicles, and blanching of the skin. These observations are not necessarily applicable to human skin, but if they were it would seem reasonable to use the drugs either locally or systemically for treatment of any skin diseases associated with hyperkeratosis, increased dermal fibrosis and seborrhea. Unfortunately, prolonged systemic use of ACTH and cortisone produces acne and hirsutism,[9] thereby encouraging the seborrheic state.

Both hormones are said to inhibit the formation of granulation tissue,[7] but healing of this type does not take place in dermatitis and superficial dermatoses. Recent reports suggest that burns[2] heal more rapidly when ACTH or cortisone is given and that skin grafts may have a higher percentage of "takes" when these drugs are used.[22]

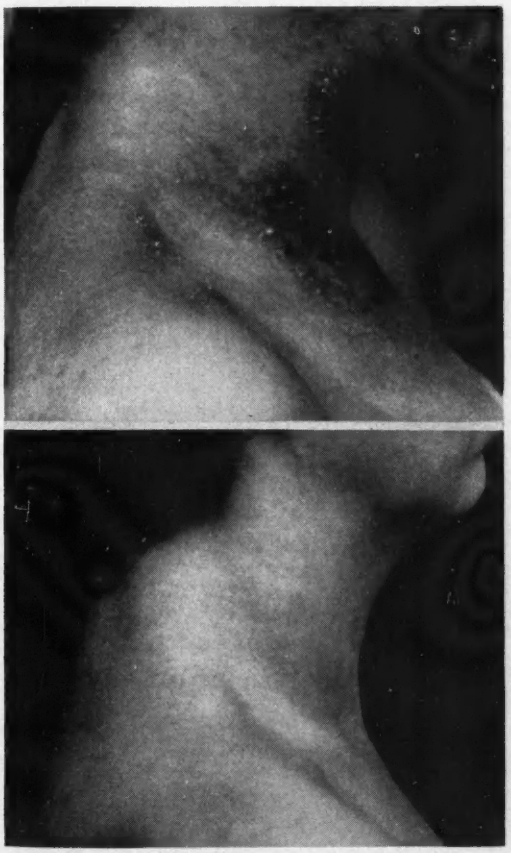

Figure 1.—Severe atopic dermatitis, before and six days after treatment with cortisone.

Figure 2.—Pemphigus vulgaris, before and one month after treatment with cortisone.

Experimentally ACTH and cortisone have been found to inhibit the anaphylactoid reaction[8] and the production of the Arthus phenomenon,[4] possibly by the prevention of the formation of antibodies. Also, ACTH and cortisone have been used successfully in treatment of a variety of allergic disorders.[6, 10] Use of the hormones in treating atopic dermatitis, infantile eczema and allergic drug eruptions, as well as the numerous types of sensitization dermatosis, would thus seem reasonable.

Both ACTH and cortisone usually cause pronounced euphoria and psychological uplifts. This effect must be considered when reviewing the results of therapy in dermatoses that are aggravated or caused by emotional disturbances. The euphoric effect of the steroids may be important in the relief of itching. However, these hormones may have a direct antipruritic effect. It is in treating pruritic dermatoses that these hormones appear to be of the greatest value. It must be kept in mind that a transitory depression may occur after use of the drugs is discontinued.

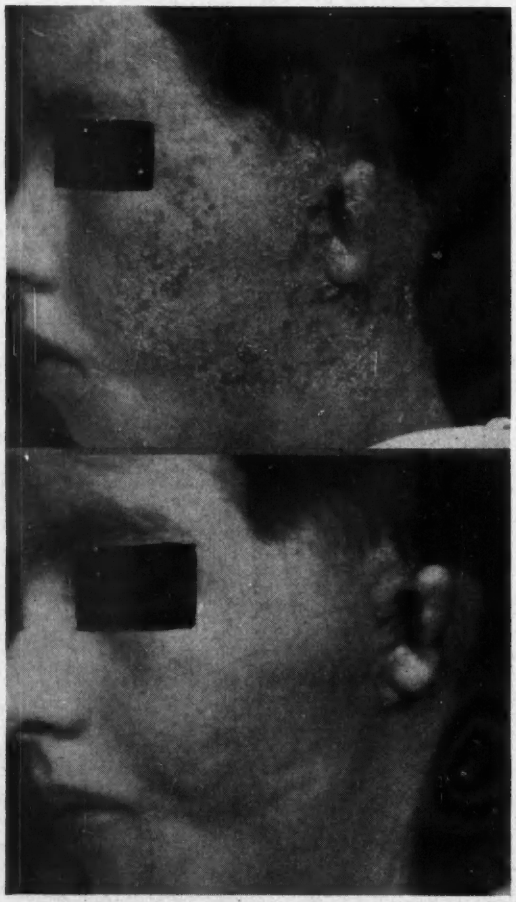

Figure 3.—Infectious eczematoid dermatitis, before and four days after treatment with cortisone.

COMMENT

The results of therapy with ACTH and cortisone in skin diseases have not measured up to the hopes for them. The drugs have been sufficiently studied to permit the conclusion that the disease process is seldom if ever reversed. The symptoms and external evidence of the disease become obscured only to reappear when the drugs are discontinued. The fact that a small number of patients with atopic dermatitis have relapse when steroid treatment is discontinued, and then recover, may be due to the fact that while ACTH or cortisone is being given the anterior pituitary and the adrenal cortex become temporarily inhibited. Then, when the exogenous hormones are cut off, there is a temporary delay in the endogenous production of ACTH and glucocorticoid hormones[9] with the result that the itching and skin eruptions reappear until the anterior pituitary or adrenal cortex starts secreting normally again. Therefore, the period immediately following discontinuance of hormonal therapy may be a critical one, for it may be decided then whether or not there will be complete relapse.

In biopsy of material taken from patients in the four cases of chronic discoid lupus erythematosus in the present series, pathologic changes characteristic of the disease were noted following treatment. In the cases of atopic dermatitis, striking histologic resolution was noted following therapy (Figure 4).

Severe complications occasionally occur with the use of these hormones. They are edema, hypochloremic hypokalemic alkalosis, hypertension, hyperglycemia, acne, hirsutism, striae atrophicae, keratosis pilaris, amenorrhea, the "moon face" and fat distribution associated with Cushing's disease, osteoporosis, and psychic changes.[8, 11] Although these are reversible changes and the more serious ones occur only after prolonged treatment, they indicate the need for caution in deciding to use these drugs for dermatitis which can be treated successfully by other methods. However, in such critical conditions as pemphigus vulgaris, ACTH and cortisone may be the only effective therapeutic agents available. Because of certain complications which occurred during treatment of one patient with atopic dermatitis, the following case is reported.

CASE REPORT

A white American housewife, 55 years of age, was admitted to hospital with complaint of extensive itching eruption of nine months' duration. Conservative therapy had not been effective. A diagnosis of atopic dermatitis was made. ACTH was given and within three days the skin was almost clear. Crusting impetigo of the face caused by coagulase-positive staphylococci and hemolytic streptococci, both sensitive to aureomycin and chloramphenicol, then developed. When the impetigo did not abate after four days of antibiotic therapy—aureomycin locally and chloramphenicol by mouth—ACTH was discontinued and the lesions cleared in the next 24 hours. Then, however, there was a slight relapse in the neurodermatitis. ACTH therapy was resumed and rapid improvement again was noted. The patient was discharged with prescription of a maintenance dose of corti-

sone. Two days later she was readmitted in a state of severe confusion and mania. Paranoid schizophrenia (previously existing) was diagnosed. While the patient was completely out of touch with reality, the skin was clear but the eruption gradually recurred as the mental status improved. When last observed, seven months after hospitalization, the patient was in a vastly better psychic state and the condition of the skin was slightly improved.

In this case there were two complications of ACTH and cortisone therapy. The first was pyogenic infection which would not heal while ACTH was being given, possibly due to the inhibition by the hormone of the immunizing reactions of the tissues or to an alteration of the powers of the circulating leukocytes.[3] The rapid improvement following the withdrawal of the hormone points to some interference in tissue reaction to infection. It is well known that ACTH and cortisone do have certain psychic effects. Euphoria is by far the most common, but depressive states do occur and possibly other aberrant psychic states can develop. The opinion of Hoffer and Glaser[5] is that ACTH and cortisone do not cause psychosis but merely bring to light a condition that was already present. In the case reported herein, the schizophrenic state had been present previously.

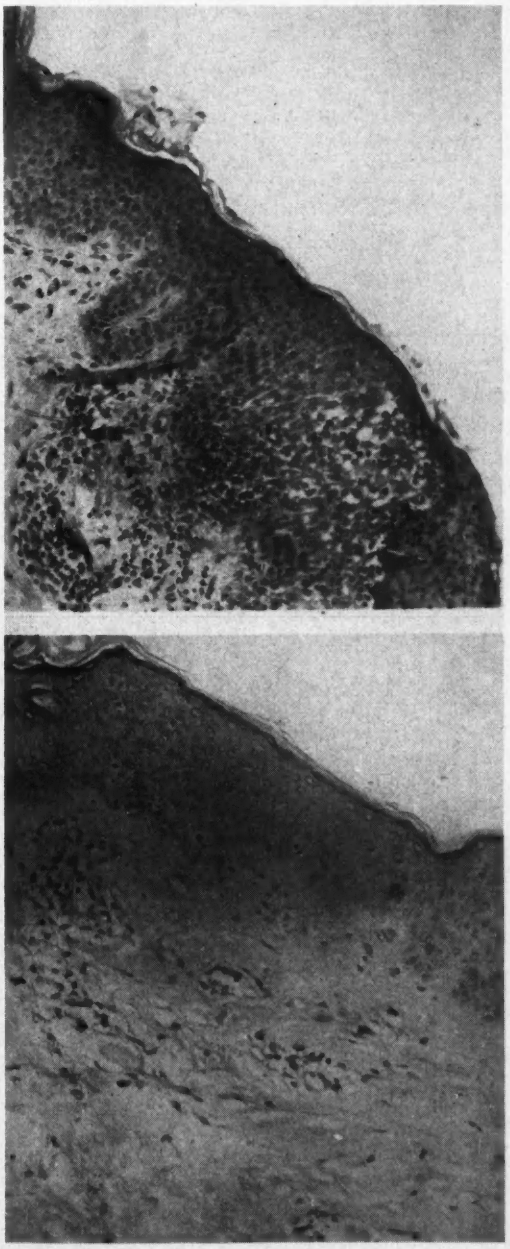

Figure 4.—Skin, arm, atopic dermatitis, before treatment and at eighth day of cortisone treatment.

ACTH or cortisone therapy is indicated in atopic dermatitis if the condition has been present for a long time and is refractory to all other methods of therapy. Use of the steroids may break a vicious cycle and shorten an already long drawn-out disease, but this cannot be a firm conclusion until reports of longer follow-up periods are available. These agents should be used until a maximum effect is reached and then reduced gradually to a maintenance level. Bland topical therapy with sedation should be instituted at the same time, and if the ACTH or cortisone is gradually withdrawn, a rebound relapse may thereby be prevented.

In cases of atopic dermatitis in which there is a strong emotional element, psychotherapy might well be begun when treatment with ACTH or cortisone is started because of the euphoric state which seems to make the patient a more willing subject. Three patients in the present series were treated in that way and after three months of follow-up the results were very encouraging.

CONCLUSIONS

Cortisone and ACTH therapy should not be used indiscriminately in patients with diseases of the skin. In all dermatoses, except those which are usually of a temporary nature, results with ACTH and cortisone are disappointing. At present it cannot be said that any of the patients in the series here reported upon were cured. Although in seven of 22 cases of atopic dermatitis there were remissions of from two to five months at the time of report, this is not a long enough time to permit conclusion that cortisone or ACTH will break the cycle of periodic relapses in such cases.

Results of studies by the authors and by other investigators would appear to indicate a definite place for the use of ACTH or cortisone in treating "drug eruptions" and long-standing cases of atopic dermatitis where other methods have failed.

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Control of Pulmonary Hemorrhage by Intravenous Use of Pituitrin

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SUMMARY

Pituitrin® is the best available drug for control of severe pulmonary hemorrhage. It must be used intravenously to be effective. Untoward effects are minimal and transient if the technique described is scrupulously followed.

It can be used immediately for control of pulmonary hemorrhage from whatever cause. An adequate diagnosis of the pulmonary condition responsible for the hemorrhage must then be made.

THE intravenous use of pituitary extract for the control of pulmonary hemorrhage was first suggested by the physiologist Carl J. Wiggers in 1911.[23, 24] Wiggers carried out a series of experiments on animals, using several different drugs, and he concluded: "The drug that combines an ability to elevate the systemic arterial pressure and simultaneously to lower that in the pulmonary circuit is the ideal physiological agent to employ. In the entire gamut of drugs investigated, pituitary extract is the only one that possesses this fortunate combination of actions." Following Wiggers' report, specialists in diseases of the chest in this country began to use Pituitrin.® They gave it intramuscularly, however, instead of intravenously, and its effect on pulmonary bleeding when used in this manner was disappointing.[4, 9, 21] It remained for the French physician Edouard Rist to use pituitary extract intravenously. He reported 12 cases to the Medical Society of the Hospital of Paris in 1913[18] and in each of these there was almost immediate stopping of the pulmonary hemorrhage. In a book, published in 1943, Rist[19] stated, "Intravenous injection of Pituitrin is so superior to the other treatments of hemoptysis that it is perhaps not very profitable to spend time on the other drugs used medically for this purpose."

It was the review of Rist's book that led the late Max Pinner to suggest to the authors, in 1947, the intravenous use of Pituitrin to control bleeding from the lungs. Since that time the authors have administered or supervised the intravenous administration of pituitary extract on 78 occasions to 48 patients. The great majority of the patients had severe or repeated hemoptysis, and the control of bleeding was usually quite prompt. Obviously, no drug can be of any avail in sudden massive hemoptysis such as may be caused by hemorrhage from the rupture of an aortic aneurysm or of a Rasmussen's aneurysm of a large vessel.[2, 14, 17] Also, the authors do not resort at once to the intravenous use of Pituitrin for the control of slight hemoptysis or of bleeding that causes only streaking of the sputum. In such cases, strict bed rest, mild sedation of the cough reflex and reassurance are usually all that is necessary to control the bleeding. It is in cases of hemorrhage intermediate between the extremes mentioned—cases in which there is brisk bleeding or repeated moderate episodes of bleeding—that the intravenous use of Pituitrin has been observed to be most effective. In such situations, the result is almost as if forceps had been applied directly to the bleeding vessel. Dale,[3] reporting upon experimental studies, said that in animals the vessels in the lungs, like those in other tissues, are constricted by pituitary extract.

It is, of course, of paramount importance to determine the cause of bleeding once the acute phase has subsided, unless the cause is already known. In the cases upon which the present report is based, the causes of bleeding, in the order of frequency, were pulmonary tuberculosis, bronchiectasis, lung tumor, coccidioidomycosis, and rheumatic heart disease.

TECHNIQUE OF ADMINISTRATION

The technique of administration, as previously described,[22] is to dilute 10 international units of Pituitrin (1 cc. of Obstetrical Pituitrin or 0.5 cc. of Surgical Pituitrin, Parke, Davis and Company) in 10 cc. of normal saline solution and to inject this solution slowly over a ten-minute period into a vein in the arm. The patient is kept in the supine position. During the injection the pulse rate may not change or it may accelerate slightly. The blood pressure usually remains constant before and after injection. A short time after the introduction of the drug into the blood stream, the patient may complain of dizziness, and the powerful vasoconstrictor action of the drug is noted in an intense pallor of the face and extremities. This may be followed by slight abdominal cramping and an urge to empty the bowels and the bladder. Nausea is of common occurrence toward the end of the injection and it may result in the emesis of clotted blood swallowed during the course of the hemoptysis. It is well to keep a bedpan and an emesis basin handy. These effects rapidly disappear. No serious untoward effects have been observed.

Following the injection, the patient may continue to raise clots of blood and small amounts of blood-streaked sputum, but this is from residuum in the

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bronchial tree, not from fresh bleeding. Further bleeding may occur after a period of hours or days, necessitating further intravenous injections of the drug, but, in general, one intravenous injection of pituitary extract will serve to control the most severe episode of pulmonary hemorrhage.

Although the authors have not had occasion to use Pitressin® intravenously, the pharmacological literature reviewed would suggest that this drug has the same vasoconstrictor action as Pituitrin and is devoid of the undesirable oxytocic principle.[7, 15, 20] There is some evidence to indicate that the toxicity of Pitressin is greater than that of Pituitrin.

Experimentally, both drugs have been observed to have a powerful vasoconstrictor action on the coronary circulation as well as on the peripheral circulation.[6, 13] Katz,[6] in experiments on a normal denervated dog's coronary vessels perfused in situ with defibrinated dog's blood, found it was possible to make direct determination as to whether a substance has a vasodilator or vasoconstrictor action on these vessels. Besides the direct effect of the drug in actively altering the caliber of coronary vessels, it may also passively change their caliber by its other actions. It is the change in the ratio of coronary caliber and coronary flow to the work and energy expenditure of the heart that is the important criterion in determining the value of any drug. Pitressin was observed to cause powerful vasoconstriction in these experiments; and it was noted that with large doses the utmost effect may be continued for half an hour or more.

Kolls and Geiling,[7] using Pituitrin intravenously in dogs, observed that it caused a paling of the skin and of the visible mucous membranes. This reaction was more pronounced in animals that were not anesthetized than in those under ether anesthesia. With larger doses, apnea with alternating periods of rapid, shallow respiration occurred as a constant phenomenon in animals that were not anesthetized. In animals under ether anesthesia, little change in respiration was noted. Circulatory changes noted in unanesthetized dogs were: (1) a rise in the mean pressure due chiefly to increase in diastolic pressure indicating increased peripheral resistance (systolic level plays a subordinate role); (2) a decrease in the pulse pressure; (3) a pronounced slowing of the cardiac rate; (4) a decrease in the minute volume output of the heart, although the output per beat may be unaltered or may be lowered. Cardiac dilatation, observable fluoroscopically and in x-ray films, may occur. These changes, indicating intense peripheral constriction of arterioles and capillaries, were verified by direct observation of blood vessels in the dog's ear. Slowing of the heart occurred after removal of vagus influence by large doses of atropine sulfate, suggesting direct action on the myocardium or diminished coronary flow.

Melville[10] also showed by experimental methods that any deleterious cardiac effects induced by the injection of a large dose of posterior pituitary extract in normal unanesthetized dogs were entirely secondary to the coronary constricting action. No evidence of any direct injurious effect of the extract on the myocardium could be demonstrated.

Ross, Dreyer and Stehle[20] stated that the coronary flow and cardiac output, determined simultaneously in experimental animals before and after Pituitrin was given, indicated that coronary spasm is one of the important factors which may cause a fall in blood pressure under certain conditions. (The authors have observed no such effect in patients who were given Pituitrin in the dosage and by the method previously described.)

Woodbury, Hamilton and Volpitto[25] observed transient decreases of 30 to 50 mm. of mercury in arterial pressure in anesthetized and unanesthetized patients following intravenous and direct uterine administration of surgical or obstetrical Pituitrin. They also noted that the intravenous administration of 3 units of Pitressin caused very small rises in blood pressure.

The vasoconstrictor action of pituitary extract is apparently greatly enhanced by the use of barbiturates, particularly barbiturate anesthetics such as sodium Pentothal.®[1, 5, 11]

Although the authors noted no difficulty attributable to coronary constriction in the intravenous use of Pituitrin in several elderly patients with rather advanced generalized arteriosclerosis, in view of the experimental observations it is well to be on the lookout for such an effect. However, use of Pituitrin in the dosage and with the technique previously described seems not to entail difficulties of that kind. Rist, in much longer and wider experience, noted no untoward incidents he could attribute to coronary constrictive action of Pituitrin.

EFFECT WHEN USED WITH BARBITURATES

There are numerous references in the obstetrical and anesthesiological literature to the use of Pituitrin, largely by injection intramuscularly or directly into the uterus. It has been reported that giving Pituitrin to obstetrical patients who have had analgesic doses of barbiturates may have an adverse effect. Raginsky and Stehle[16] noted that cardiac sensitivity to the harmful effects of pituitary extract was greatly increased—as much as twenty fold—if the heart was perfused with blood containing sodium phenobarbital. They expressed belief that sodium phenobarbital reduces the work capacity of the heart muscle so that the impairment of the coronary circulation by pituitary extract has a more pronounced deleterious effect.

Koppanyi[8] noted increased incidence of Pituitrin shock when the drug was given in connection with barbiturates.

Hesselschwerdt and Medbury,[5] discussing circulatory collapse following the combined use of Pituitrin and Pentothal, noted that barbiturate anesthesia has a definite catalytic effect in producing collapse when combined with Pituitrin. Pituitrin shock is a definite clinical entity. The posterior pituitary extract contains an oxytocic and pressor factor. Pitocin,® which contains the oxytocic factors, stimulates the myometrium. Pitressin, which contains the pres-

sor factor, constricts capillaries and small arterioles. Pituitrin shock appears to be the end result of the pressor factor on the coronary arteries. The role of Pentothal in precipitating Pituitrin shock is not specific. With regard to direct depressive effect on the myocardium, phenobarbital differs from Pentothal chiefly in duration of action. Hesselschwerdt and Medbury expressed the opinion that Pituitrin and Pentothal, used together, have synergistic effect that causes myocardial anoxia: The coronary constriction of Pituitrin and the direct myocardial depression of Pentothal may produce shock.

Adelman and Lennon,[1] discussing Pituitrin shock, described an anaphylactic reaction—skin edema, urticaria, dyspnea, and shock—in a patient who then responded to epinephrine plus intravenous administration of fluid. In reviewing reports in the literature and seven cases of Pituitrin shock they had observed in anesthetized patients, Adelman and Lennon called attention to the occurrence of bradycardia, which, they believed, might be due to vagal stimulation, to direct myocardial action, or to intense coronary constriction.

The authors have not observed untoward reactions in any of the patients who were given Pituitrin intravenously, in the manner previously described, for the control of pulmonary hemorrhage. Nor have such reactions been noted by Rist when using Pituitrin according to this technique. None of the patients observed by the authors had had more than minimal doses of barbiturates within several hours of the time Pituitrin was injected.

The coronary dilating action of ephedrine and epinephrine apparently counteracts the constricting action of Pituitrin in experimental animals (Melville and Stehle[12]). This has been confirmed clinically. The manner in which this antagonistic action occurs is not entirely clear. (The authors have had no occasion to use these substances.)

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Public Relations in the Practice of Allergy

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SUMMARY

Because allergists are in a fairly recently developed and not widely well understood specialty, they must give more than ordinary attention to good relations with the public and with other physicians.

They can help put their specialty in the proper light by:

1. Explaining rather than attempting to conceal, diagnosis and treatment of allergic disease to practitioners in other fields of medicine.

2. Acknowledging the referral of patients and giving the referring physician reports on the progress of each patient.

3. Explaining to patients the nature of allergic sensitivity, the procedures necessary for diagnosis, and the probability that cure will take a relatively long time and, hence, probably will be more costly than is treatment of simpler diseases.

4. Avoiding confusing patients by giving advice, based on faddist notions, which may conflict with more conventionally grounded information given by another physician.

5. Making certain that all members of the office staff have and exercise the ability to make patients feel good. Disruption of physician-patient and nurse-patient relationship by pecuniary considerations must be averted.

PUBLIC relations is that relationship or association which exists between any individual or organization and the public. Thus, public relations for the allergist cover the entire scope of his relationship with all segments of the population, both lay and medical.

Since allergy is one of the most recently developed specialties in the field of medicine, there is probably no other specialty which is more in need of a good, sound approach to public relations. This is true not only as it applies to the allergist's relations with his patients and the lay public, but also to his relations with other specialists and general practitioners.

Just as in all other branches of medicine, or indeed in any human endeavor which necessitates human relations of any kind, the art of making people feel good is quite as important to the successful allergist as is medical knowledge, skill and training. In fact, this ability at times seems almost to overshadow true medical skill. Physicians found wanting in their technical approach to medicine may nevertheless be extremely successful in the art of medicine. On the other hand, a physician may have had excellent training and be possessed of great technical skill yet be unsuccessful in patient relations. Some physicians, like successful men in other fields, seem to possess inherently the ability to make others like and trust them. Such men are indeed fortunate. Human relations, or public relations, for these favored few are always successful. Instinctively, they generate in their patients a feeling of security, confidence and well-being. However, for the vast majority of physicians this art must be acquired and cultivated.

The profession of medicine is most often chosen because of a profound longing to help suffering humanity by healing its ills and binding its wounds. Such an urge is accompanied by a natural desire for affection and appreciation from the patient, and when such a response does not occur, the physician as well as the patient suffers from a feeling of frustration. When such a feeling exists, the doctor is not likely to achieve the best results, and the patient, baffled and dissatisfied with both the results and his relationship with the physician, is certain to look elsewhere for more satisfactory doctor-patient relations.

Ideal, or nearly ideal, patient relations can be attained by physicians as a whole, and allergists in particular, if sufficient thought is given to the problem and constant effort and care are exerted. Because allergy is such a new specialty, much misinformation has been and is still being disseminated both by the medical profession and by the lay public. Popular magazines constantly appear with articles about allergic disease which have been written by wholly unqualified persons. Many physicians in other specialties and in general practice either refuse to acknowledge, or fail to recognize, an allergic condition, or they treat it incorrectly with resultant dissatisfaction to both the patient and the physician. This builds up an unjust antagonism toward the science of allergy in the minds of both the patient and the physician. Some allergists, themselves, are in part to blame for such an unhappy situation. Within the specialty are physicians who do not wish to explain allergy to other practitioners but take the attitude that by keeping all this knowledge within their specialty they keep others out of the field. This is fallacious thinking, for by helping physicians in other fields to properly care for patients with mild

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allergic disease, good will for the entire specialty is built up and successful results are obtained which do much to impress upon the public the value and importance of this specialty. With antagonism absent, patients with severe and acute allergic disease will be referred to specialists.

In certain medical fields, such as surgery, for example, only limited cooperation and effort are required from the patient. The results depend almost entirely upon the skill of the surgeon; except for the period of convalescence the patient takes no active part in correcting his condition. This is not true with allergy, however. Patients with allergic disease must cooperate and cooperate if satisfactory results are to be attained. Consequently, the fullest possible explanation should be given to the patient concerning his condition, its cause, the treatment for it and the probable prognosis.

It is desirable that this explanation be not technical; the fewer the medical terms used, the clearer the explanation. A long discussion of allergy in difficult medical terms not only fails to enlighten the patient but may either frighten or bore him.

Since hyposensitization is a long and tedious process, requiring the fullest cooperation on the part of the patient, it is well to give him some idea of this at the first consultation. It is not wise to present the problem in such a frightening way that the patient becomes completely discouraged and decides that the cure is worse than the disease; but neither should such a rosy picture be painted as to give him the impression that a half-dozen office visits and the application of a few tests are all that will be required to eliminate the disease and make him feel entirely well again. He should be made to know that considerable testing is usually necessary and that injections may have to be taken for a fairly long period. On the other hand, he should be encouraged in regard to the ultimate outcome. Also, if the patient is suffering acutely from some allergic condition, nothing will so build his confidence in the allergist as the immediate, if temporary, relief which can be obtained from some of the antihistaminics.

It is very necessary to emphasize the importance of diet and avoidance of known allergens. Since it is in these matters that the patient's cooperation is of greatest assistance, these points should be stressed at the first consultation.

OFFICE PERSONNEL

It is of the greatest importance to choose office assistants who are not only capable but who also make the patients feel good. In the practice of allergy, which involves frequent office visits by the patient over a long period, it may not be possible or practical for the allergist to see the patient at every visit. As the nurse, rather than the physician, often deals with the patient, it is imperative not only that she be competent and well trained, but that she have, in pronounced degree, the ability to make people feel good. This is also true with regard to the receptionist, bookkeeper and secretary, whether all the jobs are done by one person or by several persons. A surly, unpleasant or harsh telephone voice, for instance, can drive patients away before they even make the first appointment. A cheerful, friendly and interested telephone voice, on the other hand, establishes friendly relations at once.

Discussion of the cost of treatment at the patient's first visit is highly desirable. In this way misunderstandings are avoided and the basis is established for much happier relations throughout the entire period of treatment. This discussion may be between the doctor and the patient, or if a bookkeeper is employed, it may be desirable to have her assist with the financial arrangements.

An allergist should never himself press a patient for payment of an overdue bill; that is a task for someone not directly involved in the physician-patient relationship. If the physician or a nurse who deals with the patient clinically has to take action to collect a bill, the friendly patient relationship is disrupted and very often completely destroyed. The patient often discontinues treatment entirely, although in some instances he may go elsewhere. In either case, all or most of the effort expended has been fruitless both for the patient and the doctor. However, if there is a third person in the office who can handle the business side of the patient relations, the sympathetic and friendly association between the doctor and the nurse and the patient often remains undisturbed even when payment is made reluctantly.

In the matter of collections, the greatest of care must be exercised in order to maintain friendly relations. It is to be expected that the bookkeeper will be the recipient of all complaints, whether warranted or not, concerning bills. Firmness is necessary where financial matters are concerned, but this should be accompanied by an unfailing attitude of friendliness and helpfulness and a willingness to hear the patient out. When a patient is angered over a bill, whatever may be the reason, nothing so relieves his feeling of resentment as being able to tell the person whom he considers responsible just what he thinks about the whole matter. Many times his ruffled feelings can be soothed and he will leave the office feeling pretty good after all if he has been permitted to get the whole matter off his chest and has been met with friendliness and understanding, notwithstanding that he still has to pay the bill.

Better public relations can be established if the subject of allergy is better understood by the public. One way to reach the public is by accurate but nontechnical articles in lay magazines and other publications. Aso, when opportunity presents, it is well to give brief and interesting talks before various lay groups such as parent-teacher organizations, service clubs, breakfast clubs and the like. It also furthers friendly relations if the allergist affiliates himself with some good lay organization such as a service club. In this way he comes to know business men and men from the other professions in a friendly, informal way, and such associations go far to build confidence and respect for his specialty.

A large percentage of an allergist's practice will

naturally come from other physicians who refer their problem cases to him, and an excellent means of building good public relations is to acknowledge such referrals at once. A simple printed card on which the patient's name is added in the appropriate space can be used and should be mailed immediately following the first visit. After study of the patient has been completed a full report should be mailed to the referring physician, and if hyposensitization treatments are given in the allergist's office, progress reports should be forwarded from time to time. If the patient is returned to the referring physician for hyposensitization treatments, careful supervision should be maintained by the allergist. A satisfactory way to attain this end is to determine the maximum interval that is desirable between visits to the allergist's office and then supply just enough antigen to take care of the injections for that length of time. As the patient usually will return when the antigen supply is exhausted, supervision is maintained. The results thus obtained are far more satisfactory than they would be otherwise, and a feeling of good will is engendered for the allergist and for the specialty as a whole.

HELPING OTHER PHYSICIANS

It is no secret that other specialists and general practitioners are treating most patients with allergic disease in their own office. Such being the case, it is extremely foolish for an allergist to attempt to keep all special knowledge of treatment within his own specialty. Instead, he can render his specialty a real service by instructing other physicians in the rudiments of good practice in his field. This can be done by speaking, when invited to do so, before various medical groups such as meetings of other specialists, county medical society meetings, and hospital staff meetings. Allergists who can do so should also write articles for the various medical journals. Good will and friendliness for individual allergists, and so indirectly for the entire specialty, is generated by regular attendance at various medical meetings and a display of genuine interest in other physicians' problems and difficulties.

Physicians who do not specialize solely in the practice of allergy seldom wish to stock the necessary material for complete allergenic studies and hyposensitization treatments but content themselves with applying a few skin tests and injecting one or two stock antigens. Symptomatic treatment with the antihistamines frequently is used in conjunction with this treatment. In simple, uncomplicated cases of seasonal allergic rhinitis, urticaria and angioneurotic edema, such care is often effective. However, when a patient has a more serious and complicated allergic disease, treatment of that kind is inadequate. Accurate information concerning allergic conditions actually encourages general practitioners or other specialists to refer such patients to allergists.

There is a growing tendency among allergists to go off on tangents and to emphasize certain etiological factors to such a degree that they lose sight of the general field of allergy. This is especially true of allergists who wander into the field of psychosomatic therapy; they may have patients psychoanalyzed and then depend upon their particular brand of psychotherapy instead of relying upon the standard, proven techniques. Certain of these hybrid allergists have a mania for speaking before all sorts of medical and allied groups in order to plump for their particular notions. They have thus obtained national publicity which has been very detrimental to the specialty of allergy because the information thus disseminated both to physicians and to laymen is false in that it has given the idea that there is no need for study of more than a single facet of allergic disease, or for diagnosis and skin testing, and that hyposensitization treatments are wholly unnecessary. Any reputable allergist will agree that in many cases of allergic disease there is a psychogenic factor for which treatment should be given; but to blame the entire condition on this cause, and to treat only for that, is as fallacious as to treat all maladies wholly with prayer.

Recently the author referred a patient to another allergist because the patient wished to be sent to a physician close to his home. Complete information as to diagnosis and treatment was forwarded to the other allergist, together with specific antigens. Receipt of them was never in any way acknowledged. Later the patient reported that the physician criticized the author's method of diagnosis, refused to continue the recommended treatment, and failed to obtain satisfactory results. The patient's confidence in the efficacy of allergic treatment was completely destroyed.

Not long ago a patient who had gone to another allergist came to the author. She had bronchial asthma, allergic rhinitis, gastrointestinal allergic disease, migraine, and recurrent attacks of urticaria. Despite this history, skin tests with only a very few of the pollens and other inhalants had been carried out. The patient had never been questioned concerning food habits, and no food tests were applied. The allergist had told the patient that food had nothing to do with her condition and that, in his opinion, food was not a factor in allergic disease. When skin tests were applied by the author, very severe reaction to a number of common foods was noted. A food diary was kept and it was noted that symptoms developed after ingestion of certain foods. Sensitivity to a number of pollens and inhalants was noted also. The elimination of the allergenic foods, together with hyposensitization, cleared the allergic condition to such a degree that further medical supervision was unnecessary.

The allergist who adopts an attitude such as the foregoing causes patients to wonder how two physicians in the same specialty could give advice so diametrically opposed, which makes for bad feeling toward the entire specialty.

Allergists frequently observe patients with very severe allergic conditions, particularly asthma and allergic rhinitis, who state that they have been under the care of various physicians who have advised

against their consulting an allergist because it will do no good, or because the expense is prohibitive or because they will have to have injections for the rest of their lives. Such advice, often given by physicians who are respected in their particular fields, indicates a lack of good public relations on the part of allergists. It stems from failure to reach these physicians with accurate information as to the cause of allergic disease, the methods and length of treatment and the fact that the expense is not exorbitant.

Some allergists become panicky when new medical discoveries are made. There were many who felt that the specialty would cease to exist when the antihistamines appeared, and more were certain that the antibiotics would eliminate the specialty. Then, when cortisone and adrenocorticotropic hormone was available the faint-hearted were positive that allergy, as a specialty, would soon be no more. It is quite true that in certain allergic conditions all of these new drugs are helpful, but no one of them is the final answer. No good allergist would fail to use these miracle drugs as a supplement to regular treatment, but they are only supplements and not magic cure-alls. They do not eliminate the need for careful allergic studies and hyposensitization for permanent and satisfactory results.

Good public relations are of vital importance to the specialty of allergy, and every practitioner of the specialty should make the building of good will toward physicians in general, and the specialty in particular, a matter for personal concern. This may be accomplished by constantly improving relations with patients, with other members of the lay public and with physicians in other branches of medicine. A conservative approach to allergy along lines and with techniques which have been proven clinically creates confidence in the specialty on the part of the lay public and among other members of the profession alike. A radical, irresponsible approach destroys such confidence. Knowing that it grew out of a great need, allergists should have faith in their specialty. The science of allergy is no fly-by-night fad; it is one of the pillars of medicine, resting on the firm foundation of clinical experience.

3875 Wilshire Boulevard.

Mediterranean Anemia

HENRY K. SILVER, M.D., *San Francisco*

SUMMARY

There are two forms of Mediterranean anemia, one mild, the other severe. The major variety is characterized by pronounced anemia and systemic changes. In the minor form, usually there is no anemia or other clinical abnormality. The milder disease is relatively common in Italians, but both forms may occur in persons of non-Mediterranean ancestry, as well as in those who come from areas adjoining the Mediterranean Sea. Diagnosis of the disease is made on the basis of history, clinical observation, roentgen studies of the bones, and exceptionally painstaking laboratory tests. Periodic transfusions of whole blood are necessary for persons with the more severe form of the disease.

IN 1925, Cooley and Lee[5] described a series of patients with anemia, splenomegaly, and changes in the bones which made up a disease entity that became known as "Cooley's anemia," "Mediterranean anemia," "erythroblastic anemia," "thalassemia," "target-cell anemia," and "hereditary leptocytosis." The purpose of this presentation is to point out the important diagnostic criteria, to emphasize the relative frequency with which the condition occurs, and to indicate the variations which may occur in this disease.

Mediterranean anemia is probably due to an inherited defect of the erythrocytes which may result from an inability to synthesize hemoglobin, or to utilize iron in a normal fashion. It may occur in a severe form, characterized by pronounced changes in the blood and in various organ systems, or it may be of a minor order with little or no anemia and no systemic changes. Formerly, it was believed to be a relatively rare disease, but in recent studies[19] of persons of Italian descent it was observed that the severe variety occurred approximately once in 2,500 births, and the lesser condition once in each 25 persons. In any family in which one member has the severe form of the disease, other members have the mild form.

The diagnosis of Mediterranean anemia can be made with comparative ease if it is of the severe type; but diagnosis of the milder form, on the basis of results of routine examination of the patient, is difficult. However, by proper testing of the patient and a study of the family, the correct diagnosis can be achieved. It is almost mandatory for the physician to supervise closely and participate in the interpretation of the various laboratory tests. In most instances a technician's report of the available data must be further evaluated by the physician. He should examine blood and bone marrow smears himself in order that he may observe the important, but easily overlooked, changes that may be present.

The major form of Mediterranean anemia is characterized clinically by: anemia, which starts in the first year of life and may be associated with very slight jaundice; enlargement of the liver and spleen, which may be of such degree as to cause abdominal distention; flattening of the face, with prominence of the cheek bones, causing a mongoloid appearance; and eventual enlargement of the heart, and chronic passive congestion as a result of repeated severe episodes of anemia.

Roentgen examination of the bones may be of aid in diagnosis of the severe form. Departure from the normal architecture may be noted. In the skull there may be widening of the marrow spaces, thinning of the outer and inner tables, and perpendicular ("hair on end") striations between these tables. However, although the changes of the skull are mentioned most often, in the author's experience the earliest and most pronounced changes usually occur in the metacarpal bones and in the distal portion of the humerus and proximal part of the ulna. In the medullary portions of the bones, decreased density, increased prominence of the trabeculae, and widening of the medullary space may be noted before any abnormality of the cranium is present.

Patients with Mediterranean anemia do not have crises with abdominal pain and evidence of severe hemolysis such as may occur in other congenital anemias of childhood.

Although the disease in both its major and its minor forms is most common in the peoples of the area surrounding the Mediterranean Sea (especially Italy, Greece, Syria, and Armenia), an increasing number of cases is being reported in non-Mediterraneans—in persons of Argentine,[2] Egyptian,[8] Chinese[10, 12, 13, 24, 29] English,[1] French,[20] German,[11] Indian,[3, 4, 7, 16, 17, 18, 21] Negro,[6, 9, 15, 23, 28] Philippine,[27] Spanish,[14, 25] and Turkish[22] ancestry. During the past four years the author has observed cases of both major and minor types in Chinese, Mexican, and French-Philippine children.[26]

Anemia is usually pronounced in persons with the major form of the disease. In most instances, the reduction in hemoglobin and in the volume of packed erythrocytes in the blood, as determined by hematocrit, is relatively greater than the reduction in the number of erythrocytes per cubic millimeter of blood. The determination of this disproportion is most important, since Mediterranean anemia is one

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of the few conditions in which the anemia is of hypochromic microcytic type.

The erythrocytes vary greatly in size (anisocytosis) and in the amount of hemoglobin which they contain. In some cells the hemoglobin that is present may be observed only as a thin layer on the periphery of the cell, while in others there may be an accompanying circular area of pigment in the center (target cell). Basophilic stippling often is noted and it may be quite pronounced. Nucleated erythrocytes characteristically are found in the peripheral blood. They may be few in number or they may outnumber the leukocytes. In addition, there is an increase in the number of reticulocytes. Increased resistance of the red corpuscles, as tested by hypotonic saline solutions, is a most significant characteristic and one of the most helpful in arriving at a diagnosis. Hemolysis of some of the cells occurs when saline solutions in which normal cells rupture are used, but some may resist even 0.20 per cent solutions.

The determination of red cell fragility often gives valuable information in this and other types of childhood anemia. It need not be performed on venous blood since a simplified method of testing, using capillary blood, has been described.*

The minor form of Mediterranean anemia usually has no clinical manifestations, although evidence of mild anemia is present in some instances. Splenomegaly, if present, is of minor degree and no abnormalities are observable in roentgen examination. This variety is numerically much more important than the major form, since it occurs about one hundred times as frequently.

The performance of most of the previously mentioned studies is essential in examination of persons suspected of having the minor condition, since pronounced changes of the blood may be present even in the absence of anemia. Like the severe disease, the minor form also is characterized by pronounced disproportion between the number of erythrocytes and the hemoglobin content of the blood. (This was especially striking in the parents of one patient who had the major form of Mediterranean anemia. The blood of the mother had a normal hemoglobin content (14.6 gm. per 100 cc.) and normal ratio of packed erythrocytes to whole blood (47 cc. per 100 cc.), but the number of erythrocytes was 7,450,000 per cubic millimeter; and in the father's blood the hemoglobin was 14.3 gm. per 100 cc., the packed erythrocyte volume was 46 cc. per 100 cc., and the

*Solutions of sodium chloride are prepared in increments of 0.05 per cent between 0.10 per cent and 0.75 per cent saline. These are kept in sterile rubber-stopped bottles. At the time of testing, approximately 1.0 cc. is withdrawn with a syringe from each bottle and placed in Wassermann tubes. One to two drops of capillary blood from the finger or toe is then mixed with the contents of each tube. The results may be noted after one hour, but the tubes are let stand for 12 to 24 hours and the results noted again. Simultaneous testing on a normal control must be done each time. The significance of the result is not the exact concentration of saline at which hemolysis begins or is completed, but the relation of hemolysis of the blood being tested to that in the blood known to be normal. By this method hemolysis in the normal subject starts in 0.45 per cent sodium chloride and is complete in 0.35 per cent or 0.30 per cent, while in Mediterranean anemia hemolysis may not be complete in 0.20 per cent saline.

TABLE 1.—*The Major and Minor Forms of Mediterranean Anemia Compared*

	Major	Minor	
		Similarity to Major	Points of Difference
Anemia	++++		0 to +
Systemic involvement	++++		0
Roentgenographic changes	++ to ++++		0
Blood:			
Anemia	Hypochromic microcytic anemia	Hypochromic microcytic but without anemia (Normal hemoglobin, high erythrocyte count)	
Anisocytosis	++++	++	
Poikilocytosis	++++	++	
Basophilic stippling	++	++	
Target cells	+++	++	
Nucleated erythrocytes	+++		0
Reticulocytes	Increased	Increased	
Erythrocyte fragility	Decreased	Decreased	
Leukocytosis	++		0
Bone marrow	Erythroblastosis	Erythroblastosis	

TABLE 2.—*Mediterranean and Iron Deficiency Anemia Compared*

	Mediterranean Anemia	Iron Deficiency Anemia	
		Similarity to Med. Anemia	Points of Difference
Signs and Symptoms:			
Anemia	++++	+ to ++++	
Systemic involvement	++++	0 to ++	
Roentgenographic changes	+ to ++++		0
Blood:			
Anemia	Hypochromic microcytic	Hypochromic microcytic	
Anisocytosis	++++	+++	
Poikilocytosis	++++	+++	
Basophilic stippling	++		0
Target cells	+++		0
Nucleated erythrocytes	+++	0 to ++	
Reticulocytes	Increased		Normal or decreased
Erythrocyte fragility	Decreased		Normal or slightly decreased
Leukocytosis	++		0
Bone marrow	Erythroblastosis	Erythroblastosis	
Response to iron	0		++++

erythrocytes numbered 7,520,000 per cubic millimeter.) Anisocytosis, poikilocytosis, basophilic stippling, target cells, and decreased fragility of erythrocytes in hypotonic saline solution all may be present even though the hemoglobin content be normal.

At times the differentiation of Mediterranean anemia from other kinds of hypochromic microcytic anemia may be difficult. It has been stated[30] that the only two causes of hypochromic microcytic anemia in human beings are Mediterranean anemia and iron deficiency anemia. In childhood the latter include deficiencies due to faulty diet, disorders of the alimentary tract (chronic diarrhea, celiac syndrome and hookworm infestation), and chronic loss of blood. Occasionally infections appear to be instrumental in producing hypochromic microcytic anemia, and this, too, may be due to iron deficiency, since infection interferes with the normal utilization of iron. In both Mediterranean anemia and severe iron deficiency anemia of childhood, there may be anisocytosis, poikilocytosis, nucleated erythrocytes in the peripheral blood, and decreased fragility of erythrocytes in hypotonic saline solution (see Table 2). Erythroblastosis in the bone marrow takes place in both diseases. However, in Mediterranean anemia target cells, basophilic stippling of the erythrocytes, reticulocytosis, and the presence of abnormality of the blood of other members of the family will help to differentiate the condition from iron deficiency anemia.

The only effective treatment of the severe form of Mediterranean anemia is periodic transfusions of whole blood. These should be given before the anemia becomes so severe as to result in pronounced fatigue, shortness of breath, and cardiac failure. Splenectomy, liver by mouth and by injection, iron by mouth and by injection, B_{12} by mouth and by injection, copper, pentanucleotides, and other hematinics all have been found to be of no value. The mild form of Mediterranean anemia usually is not incompatible with normal life, and specific treatment is not necessary.

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EDITORIALS

Public Relations at Home

Latest move in the public relations program of the California Medical Association is the offer just made to all C.M.A. members to supply them with a plaque to hang on the office wall or place on a desk or table. The plaque is addressed "To All My Patients" and carries the doctor's message that he invites the patients to discuss with him all matters pertaining to his services or his fees.

Designed by the American Medical Association as a public relations builder, the plaque is attractively made up and equipped with a back which becomes either an easel or a hook hanger. The A.M.A. has been offering it for sale at one dollar but the C.M.A. is underwriting this cost for its members in order to foster a good public relations medium.

Before making this offering, the C.M.A. public relations department made a trial run with the A.M.A. plaque. Samples were sent out to members in ten counties, with the request that they put them to use and let the Association know what reactions developed. Several weeks after these samples had been issued, a check was made to see if the plaques were in use and what sort of comments they had evoked. Results in the great majority of instances were that the plaque was in use and that doctors, nurses, secretaries and patients liked the idea.

While this opinion was not unanimous, it was found in so many cases that the larger distribution was voted. In the few cases in which the plaque was not in use, the reason most often given for not displaying it was that the practices in the office were already so nearly in line with the suggestions on the plaque that the printed message was not considered necessary. In a pleasingly small number of cases the sample plaque was not in use simply because the physician or secretary just hadn't taken the trouble to look it over and put it up.

The old adage that public relations begins at home, and the thesis that the public relations of the medical profession is actually the sum total of the public relations of each physician with his own patients, take on added meaning with this new item. It is evident that with patients, doctors, nurses and secretaries accepting this plaque in its true spirit, the true meaning of public relations will be subconsciously brought home to each. Just seeing the plaque on the wall or the desk each day is enough to remind any of these persons of his own responsibilities.

Here is a demonstration of a simple mechanism with far-reaching results. It should gain widespread acceptance.

Madera County Medical Society

Welcoming the Madera County Medical Society into the official family of the California Medical Association is a distinct pleasure. Here, for the first time, the physicians of that county have an organization of their own, to serve as a spokesman and a protector of the public health and the ethical practice of medicine.

Fifteen physicians, formerly affiliated with county societies in Fresno and Merced counties, have become charter members of the newest addition to the C.M.A. family. Their petition to the House of Delegates for a charter was promptly acted upon as an expression of home-town rule in the best tradition and in accordance with the wishes of those directly involved.

May this society prosper and take its rightful place alongside its sisters in California.

CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

Council Meeting Minutes

Tentative Draft: Minutes of the 387th Meeting of the Council of the California Medical Association, Los Angeles, December 1-2, 1951.

The meeting was called to order by Chairman Shipman in Conference Room 4 of the Biltmore Hotel, Los Angeles, on Saturday, December 1, 1951, at 1:45 p.m., recessed at 2:30 p.m. and reconvened on Sunday, December 2, 1951, in the same location at 1:00 p.m.

Roll Call:

Present were President MacLean, President-elect Alesen, Speaker Charnock, Vice-Speaker Randel, Secretary Daniels, Editor Wilbur and Councilors West, Ball, Loos, Sampson, Morrison, Dau, Ray, Montgomery, Lum, Pollock, Frees, Thompson, Shipman, Bailey and Varden.

A quorum present and acting.

Absent for cause, Councilors Green and Heron.

Present by invitation: Drs. William L. Bender, Eugene Hoffman and Elmer E. Wadsworth; Executive Secretary Hunton, Assistant Executive Secretary Thomas, Legal Counsel Hassard, Executive Secretary of the Public Health League of California, Ben H. Read; Public Relations Director and associate Clancy and Gillette, and William T. Nute, executive secretary of the San Diego County Medical Society.

1. *Minutes for Approval:*

On motion duly made and seconded, minutes of the 386th Council meeting, held November 11, 1951, were approved.

2. *Membership:*

(a) On motion duly made and seconded, in each instance, Associate Membership was voted for: Edmund D. Jung, San Francisco County; Thomas L. Nelson, Sonoma County.

(b) On motion duly made and seconded in each instance, Retired Membership was voted for: Clinton D. Hubbard, Los Angeles County; Elmer H. Johnson, Los Angeles County.

(c) On motion duly made and seconded, a reduction of dues, because of protracted illness, was voted for John E. Skaff, M.D., San Francisco County.

3. *C.P.S. Study Committee:*

On motion duly made and seconded, an appropriation of not to exceed $40,000 was voted by a three-fourths majority for the use of the C.P.S. Study Committee for employment of outside assistance in carrying out its activities.

4. *Selective Service:*

Dr. William L. Bender, Northern California consultant to Selective Service, reported on the activities of that service and of the advisory committees to Selective Service in the Association and the component societies. He reported a high degree of cooperation received from the Army, Navy and Air Force.

5. *Other Professions:*

Discussion was held on the activities of other professional groups and it was regularly moved, seconded and voted that a committee be appointed to confer with such groups on matters of mutual interest.

6. *California Physicians' Service:*

On motion duly made and seconded, it was voted that a copy of the address made before the House of Delegates of California Physicians' Service by Mr. Ransome Cook be sent to all members of the House of Delegates.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 3:05 p.m., December 2, 1951, subject to call for a later meeting by the Chairman.

SIDNEY J. SHIPMAN, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

Executive Committee Minutes

Tentative Draft: Minutes of the 229th Meeting of the Executive Committee of the California Medical Association, San Francisco, October 25, 1951.

The meeting was called to order by Chairman Lum in the offices of the Association at 2:15 p.m., Thursday, October 25, 1951.

Roll Call:

Present were President MacLean, President-elect Alesen, Council Chairman Shipman, Auditing Committee Chairman Lum and Secretary-Treasurer Daniels.

Absent for cause was Speaker Charnock.

Present by invitation were Executive Secretary Hunton, Assistant Executive Secretary Thomas, Legal Counsel Hassard and Director of Public Relations Clancy.

1. *Public Relations:*

Discussion was held on public relations aspect of Dr. Alesen's speech which he is giving before various county medical societies and several changes were suggested.

Ads prepared by the public relations staff were distributed.

2. *Complete Service Bureau, San Diego:*

Mr. Hassard reported that the brief on the case in San Diego has been completed and filed with the court.

3. *C.P.S. Study Committee:*

Mr. Hassard reported in behalf of Dr. Wilbur Bailey, chairman of the C.P.S. Study Committee. Discussion followed and motion was duly made, seconded and carried that the C.M.A. pay the expenses of the first meeting of the committee and that the committee be considered to be a special committee of the Council and that it be responsible thereto. The advisability of the committee employing a business consultant was discussed.

4. *C.M.A. Committee on Psychology:*

On motion duly made and seconded, it was voted to appoint Dr. Donald Charnock chairman of this committee and to appoint Drs. John Askey and Theodore Rothman as members.

5. *Industrial Accident Commission Committee:*

On motion duly made and seconded, it was voted to appoint Dr. William Sumner to the committee to replace Dr. Roger Barnes, resigned.

6. *Advisor to the University of California Chapter of the Student A.M.A.*

On motion duly made and seconded, it was voted to appoint Dr. James Harkness to be C.M.A. representative on the advisory committee to the University of California chapter of the Student A.M.A., replacing Dr. William Donald, resigned.

7. *Board of Vocational Nurse Examiners:*

On motion duly made and seconded, it was voted to recommend the following persons to the Director of the Department of Professional and Vocational Standards for selection of one for appointment to the Board of Vocational Nurse Examiners: Drs. Dwight L. Wilbur, Howard Naffziger, and Arthur A. Kirchner.

8. *U. S. Treasury Department:*

On motion duly made and seconded, it was voted to decline the request of the Treasury Department for use of the C.M.A. mailing list, and to offer the department a page in CALIFORNIA MEDICINE for purposes of advertising U. S. Defense Bonds.

9. *Woman's Auxiliary to the California Medical Association:*

On motion duly made and seconded, it was voted to refer the letter from Mrs. Stanley R. Truman, president, Woman's Auxiliary, to President MacLean, Director of Public Relations Clancy and to the Committee on Public Policy and Legislation.

10. *Cancer Clinics:*

On motion duly made and seconded, it was voted to refer to the C.M.A. Cancer Commission the request of Dr. James Ellis, cancer consultant, State Department of Public Health, for the establishment of standards for cancer clinics.

11. *House of Delegates Resolution No. 16—C.M.A. Educational Fund:*

On motion duly made and seconded, it was voted to refer this resolution to the Council with the recommendation that the C.M.A. accept any contribution to medical education and forward same to the American Medical Education Foundation, and that a page in CALIFORNIA MEDICINE and a section of *Rx Reading* be devoted to advising the membership of this.

12. *Physician-Owned Pharmacies:*

Mr. Hassard reported on an article appearing in the June 1951 issue of *Northern California Drug News* regarding physician-owned pharmacies.

13. *New Building—San Francisco Medical Society.*

On motion duly made and seconded, it was voted to advise each member of the Council, by letter, of the request of Dr. Francis Quinn, Building Committee, San Francisco Medical Society, and to refer the matter to the Council at its next meeting.

15. *Los Angeles Tumor Registry:*

On motion duly made and seconded, it was voted to approve the request of the Cancer Commission to change the name of the Los Angeles Tumor Regis-

try to "Tumor Tissue Registry, Cancer Commission, California Medical Association."

16. *C.M.A.-C.P.S. Liaison Committee:*

On motion duly made and seconded, it was voted to approve the report of this committee on the negotiations with the Sailors Union, subject to the approval of the Council.

Adjournment:

There being no further business, the meeting was adjourned at 5:15 p.m.

DONALD D. LUM, M.D., *Chairman*
ALBERT C. DANIELS, M.D., *Secretary*

In Memoriam

BENNETT, MABEL C. Died in Berkeley, January 21, 1952, aged 63, of cerebral vascular thrombosis due to arteriosclerosis and hypertension. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1920. Licensed in California in 1920. Dr. Bennett was a member of the Alameda-Contra Costa Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

GILBERT, BERNARD H. Died in San Jose, January 23, 1952, aged 66. Graduate of the University of Vermont College of Medicine, Burlington, 1913. Licensed in California in 1923. Dr. Gilbert was a member of the Santa Clara County Medical Society, the California Medical Association, and the American Medical Association.

✤

HOARE, HARRY J. Died in Los Angeles, January 28, 1952, aged 68. Graduate of the College of Physicians and Surgeons, Los Angeles, 1910. Licensed in California in 1910. Dr. Hoare was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

MAY, H. CAMERON. Died in Los Angeles, January 29, 1952, aged 69. Graduate of Hahnemann Medical College of the Pacific, San Francisco, 1908. Licensed in California in 1908. Dr. May was a retired member of the Los Angeles County Medical Association, and the California Medical Association.

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MERKLE, HENRY J. Died in Los Angeles, December 17, 1951, aged 54. Graduate of Northwestern University Medical School, Chicago, 1925. Licensed in California in 1927. Dr. Merkle was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

PASLEY, HARRY W. Died in Reedley, January 7, 1952, aged 67, of coronary artery disease. Graduate of Indiana University School of Medicine, Bloomington-Indianapolis, 1909. Licensed in California in 1922. Dr. Pasley was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

POTTER, WILLIAM H. Died in La Mesa, December 28, 1951, aged 82. Graduate of the University of Buffalo School of Medicine, New York, 1897. Licensed in California in 1919. Dr. Potter was a retired member of the San Diego County Medical Society, the California Medical Association, and an Associate Fellow of the American Medical Association.

✤

WILKE, JULIAN O. Died in Covina, January 15, 1952, aged 57, of coronary occlusion. Graduate of Johns Hopkins University School of Medicine, Baltimore, 1922. Licensed in California in 1923. Dr. Wilke was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

Questions and Answers about C. P. S.

Question: **Under the new C.P.S. medical contract, are the $25 and $10 allowances for x-ray and laboratory services renewed each year? If so, how can the physician know the date when a C.P.S. patient's allowances are renewed?**

Answer: Yes, these allowances are renewed each contract year. (A "contract year" covers one year from the effective date of the member's enrollment in C.P.S. under the new medical contract, or one year from the date the member's coverage was converted from the old to the new medical contract.)

The following procedure has been established so that physicians will know the status of a C.P.S. patient's x-ray and laboratory allowances: When a physician member who performs these services in his own office submits his bill to C.P.S., he is automatically sent a form which indicates (1) the amount which will be paid by C.P.S., (2) the amount of the $25 and $10 allowances which remains, and (3) the date when the allowances will be renewed.

Question: **I have two questions regarding exclusions from coverage under the Direct Payment Program: (a) Are tonsillectomy and adenoidectomy and pregnancy excluded? (b) Have athletic and occupational injuries recently been removed from the list of exclusions?**

Answer: (a) Benefits for tonsillectomy and adenoidectomy are immediately excluded when a C.P.S. member transfers from group membership to the direct payment program. (Code number shown on identification card is "OCC ——.") Benefits for pregnancy which may have been held under group membership (except surgical services for ectopic pregnancy and repair of conditions arising from prior pregnancy) are excluded nine months after transfer from group to direct payment membership.

(b) Yes, athletic injuries and occupational injuries not covered by Workmen's Compensation were recently removed from the list of exclusions under the direct payment program.

Question: **How many persons must be enrolled on a contract in order to apply for the C.P.S. provisions of $50 for hospitalization for childbirth and $50 for professional services for maternity?**

Answer: The $50 allowance for hospitalization for childbirth applies when *two or more persons* are enrolled on the *same* contract—but not when they are enrolled on separate contracts, as when a husband and wife are enrolled in separate C.P.S. groups. The $50 allowance toward the cost of professional services for maternity applies whether or not any other persons are enrolled on the expectant mother's two-visit-deductible contract.

In both instances, the member must have met the requirements of her waiting period before she is eligible for these benefits.

Question: **Are preexisting conditions covered under the new statewide Individual Family Plan contract? (Code on identification card is "064—".)**

Answer: Under this contract, all preexisting conditions are excluded for the first year of membership. The decision as to the preexistence of a condition is based on generally accepted medical knowledge and experience—not on the member's awareness of symptoms of the ailment.

After one year's membership, preexisting conditions are covered in accordance with terms of the contract, except for any condition(s) which may have been waived at time of joining.

Question: **Are veterans of the Korean War eligible for out-patient medical care under the Home Town Care Program?**

Answer: Confusion regarding the eligibility of Korean War veterans stems from the fact that the United States has not made a formal declaration of war, and because disabilities incurred in peacetime enlistments in the Armed Forces are not handled by the Veterans Administration in the same manner as service-connected disabilities received in time of war.

To rectify the situation, the 82nd Congress passed Public Law 170, which provides that disabilities occurring on or after June 27, 1950 (date of the start of the Korean War), shall be considered the same as service-connected disabilities incurred in time of war. Thus, Korean War veterans are eligible for the same benefits provided for World War I or World War II veterans under the Home Town Care Program.

Question: **What is the procedure for obtaining drug prescriptions under the Veterans Program?**

Answer: The prescription should be written on California Pharmaceutical Association-Veterans Administration prescription blanks (available from any member pharmacy participating in the program) and should be for an amount not exceeding what is needed for one month's treatment. The prescription should be given to the veteran patient, who will have it filled at a pharmacy handling VA prescriptions. The physician should see that the prescription is used only for treatment of the veteran concerned, and that it is for the service-connected disability currently under authorized treatment.

NEWS and NOTES

NATIONAL • STATE • COUNTY

LOS ANGELES

At a recent meeting of the **Los Angeles Society for Allergy**, the following officers were elected: President, Dr. Norman Shure, Los Angeles; vice-president, Dr. Elizabeth A. Sirmay, Beverly Hills; secretary-treasurer, Dr. Ben C. Eisenberg.

* * *

The Metropolitan Dermatological Society of Los Angeles has elected the following officers for the year 1952: President, Dr. Harold C. Fishman; vice-president, Dr. Stanton B. May, Glendale; secretary, Dr. Fred F. Feldman, Los Angeles.

* * *

At the annual meeting of the American College of Radiology, held last month in Chicago, **Dr. Wilbur Bailey,** Los Angeles, was elected Chancellor to the college, and **Dr. John D. Camp,** Los Angeles, was reelected chairman of the Board of Chancellors.

SACRAMENTO

The second annual session of the **Sacramento Valley Counties Regional Medical and Surgical Institute** will be held in Sacramento, April 3 and 4, 1952, at the Eastern Star Temple, 2719 Kay Street between 27th and 28th streets. Local arrangements are under the direction of Dr. Herbert W. Jenkins, regional chairman, and his committee: Drs. J. W. Rovane, Orland Wiseman, A. E. Berman, E. William Rector, and Max L. Dimick, all of Sacramento; J. D. Baker, Stockton; Max Dunievitz, Auburn; Louis C. Olker, Chico; O. C. Railsback, Woodland; J. W. Linstrum, Marysville; and L. W. Bonar, Redding. The teaching program has been arranged in cooperation with Dr. H. M. Walton, chairman of the Committee on Graduate and Postgraduate Medical Education, College of Medical Evangelists, Los Angeles. The program follows:

Thursday, April 3

MORNING SESSION

Chairman, Milton Sarkisian, M.D., Sacramento

8:30- 9:00 a.m.—Registration.

9:00-10:00 a.m.—Pathologic Physiology as a Basis for Medical Practice, Walter E. MacPherson, M.D.

10:00-11:00 a.m.—Advances and Practical Aspects of Hematology, G. Gordon Hadley, M.D.

11:00-11:15 a.m.—Intermission.

11:15-12:15 p.m.—Management of Coronary Artery Disease, William P. Thompson, M.D.

12:30- 2:00 p.m.—Luncheon and Round Table Discussion.

AFTERNOON SESSION

Chairman O. J. Hansen, M.D., Redding

2:00- 3:00 p.m.—Surgical Types of Congenital Heart Disease, William P. Thompson, M.D.

3:00- 4:00 p.m.—Use, Abuse and Limitations of Clinical Laboratory Procedures, G. Gordon Hadley, M.D.

4:00- 4:15 p.m.—Intermission.

4:15- 5:15 p.m.—Management of Lower Nephron Nephrosis, Walter E. MacPherson, M.D.

7:00- 9:00 p.m.—Dinner. Speaker: Louis J. Regan, M.D., LL.B., Avoiding Medico-Legal Pitfalls.

Friday, April 4

MORNING SESSION

Chairman, C. M. Guernsey, M.D., Chico

9:00-10:00 a.m.—Office Diagnostic Procedures in Urology, Roger W. Barnes, M.D.

10:00-11:00 a.m.—Diagnosis and Management of Poliomyelitis, Albert G. Bower, M.D.

11:00-11:15 a.m.—Intermission.

11:15-12:15 p.m.—Differential Diagnosis of the Acute Abdomen, John R. Paxton, M.D.

12:00- 2:00 p.m.—Luncheon and Round Table Discussion.

AFTERNOON SESSION

Chairman, Don C. Harrington, M.D., Stockton

2:00- 3:00 p.m.—Urethral and Bladder Diseases in Women, Roger W. Barnes, M.D.

3:00- 4:00 p.m.—Clinical Diagnosis and Pathological Physiology of Carcinoma of the Colon, John R. Paxton, M.D.

4:00- 4:15 p.m.—Intermission.

4:15- 5:15 p.m.—Diagnosis and Management of Contagious Diseases, Albert G. Bower, M.D.

SAN FRANCISCO

The 1952 annual meeting of the **California Tuberculosis and Health Association,** the **California Trudeau Society** and the **California Conference of Tuberculosis Secretaries** will be held in San Francisco, April 3 to 5. All meetings of the public health and medical sections will be held at the St. Francis Hotel. Dr. John Gompertz, Oakland, is general chairman of the program committee.

SAN JOAQUIN

Dr. C. A. Broaddus of Stockton, Director of Postgraduate Activities for the California Medical Association, was elected secretary of the Associated States Postgraduate Committees of the State Medical Societies at the recent annual meeting of that organization in Chicago. As a guest speaker at the meeting, Dr. Broaddus presented a review of the postgraduate activities of the various state medical societies from 1915 to the present.

POSTGRADUATE EDUCATION NOTICES

STANFORD UNIVERSITY SCHOOL OF MEDICINE

Clinical Ophthalmology:

March 24 through March 28, 1952.

Fee: $75.

Contact: Office of the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco 15.

UNIVERSITY OF CALIFORNIA SCHOOL OF MEDICINE

Psychosomatic Medicine:

March 17 through 21 at the Langley Porter Clinic.

Fee: $50.

Cardiovascular Diseases (mornings), Electrocardiography (afternoons):

April 28 through May 3 at the Medical Center.

Contact: Stacy R. Mettier, M.D., Head Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22.

UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE

Essential Physics in Radiology:

March 10, 1952, to May 26, 1952.

The University of Southern California Medical Extension Education is presenting a course in the Essential Physics in Radiology to be given from March 10, 1952, to May 26, 1952. This course will be offered every Monday evening from 8:00 to 10:00 p.m.; the first six lectures to be presented at the Los Angeles County Hospital and the last six at the Cedars of Lebanon Hospital. Fee for the course, $50. For further information please contact the University of Southern California Medical Extension Education office at 1200 North State Street, Barracks Building "A," Room 102, Los Angeles 33.

GENERAL

The fifth **American Congress on Obstetrics and Gynecology** sponsored by the American Committee on Maternal Welfare, is to be held March 31 to April 4 in Cincinnati at the Netherland-Plaza Hotel. In addition to a comprehensive medical program, there will be papers on nursing and public health, and a special session on sociological factors. The latest developments on proposed legislation for Emergency Medical and Infant Care will be presented by Joseph Lawrence, M.D., director of the American Medical Association's Washington office.

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C.P.S. is now issuing slightly revised membership cards in order to standardize them and to eliminate the necessity of providing separate cards to show additional coverages. The new cards will be issued to all new members, and a reissue will be made to all present members having extended benefits coverage. Present members who do not have extended benefits will retain the cards they now hold. The principal difference in the revised card is that it has an additional square (labeled "other") for the insertion of code numbers to indicate the type of supplementary coverage —*i.e.*, catastrophic coverage and/or extended benefits— which the member may hold. Another change provides a small space after the member's number (labeled "end") to indicate that waiver(s) may apply to the contract. If an "X" appears in this space information concerning limitations should be obtained from the members or from the C.P.S. Medical Department.

A two-year contest, with cash prizes for the two best theses on **research on the so-called "toxemias of pregnancy,"** has been announced by the American Committee on Maternal Welfare, Inc. The contest is open to students and personnel in the health professions who are not of higher academic rank than instructor, or who are of junior rank on the hospital or other staff with which they are connected. Theses must be based upon original work done by the authors and must be submitted no later than January 1, 1954. First and second prizes of $500 and $250, respectively, will be awarded later in 1954.

* * *

The annual meeting of the **American College of Allergists** will be held this year at the William Penn Hotel in Pittsburgh, Pennsylvania, on April 7, 8 and 9. In addition to twenty addresses on general topics and special scientific investigations, there will be round tables at luncheons and sectional meetings devoted exclusively to psychosomatic aspects, to allergic disease in infants and children, and to allergic manifestations in the skin, eye, ear, nose and throat. A session will be devoted to the problems of allergic disease in modern industrial medicine.

Immediately before the annual meeting—on April 4, 5 and 6—the college will offer an **instruction course in allergy,** also in Pittsburgh. The program has been designed for physicians in other fields, especially those in general practice, that they may learn to recognize and manage the allergic component in the complaints of patients. Further information may be obtained from the American College of Allergists, LaSalle Medical Building, Minneapolis 2, Minnesota.

INFORMATION

Changes in Disability Benefits

The California Legislature last year made substantial changes in the act which provides benefits to covered claimants suffering a disability as the result of a non-occupational illness or injury. Since these claimants receive such benefits only through certification by doctors, it seems wise to review the changes which are effective at this time.

1. *Increase in the Weekly Benefit Amount for Disability:* The program started in 1946 with a $20 a week maximum for 23 weeks; later, it was modified to a $25 maximum for 26 weeks. Now, the maximum is $30 a week for 26 weeks. The fact that the disabled unemployed covered worker may receive $30 per week as contrasted with a maximum of only $25 for those who are able to work and yet are unemployed, conceivably might cause some persons to seek certification of a disability from a physician just because of the differential rather than because of a true disability. Of course, honest medical certification, just as in the past, will eliminate this added hazard.

2. *Claimant May Receive Disability Benefits on Top of Part of Regular Wages Up to a Maximum (Partial Wages Plus Disability Benefits) of 70 Per Cent of His Regular Wage:* Previously, if a claimant received as much as $25 a week in wages while he was sick or injured, he could not be paid any disability insurance. Now, if he is unable to work because of illness or injury, he may be paid benefits even if he is receiving part of his wages. However, the wages he receives, plus the disability insurance paid him, cannot exceed 70 per cent of his normal pay.

3. *Hospital Benefits Now Paid Claimant Irrespective of Receipt of Regular Wages:* Even though an employer continues to pay a claimant his regular wages, the claimant may receive, "in addition to all benefits otherwise provided in the act," $8 for each day not in excess of 12 days in any benefit year during his confinement in a hospital—if confined therein pursuant to orders of his physician. The claimant is not subject to any waiting period requirement if and when his disability requires hospitalization. (If hospitalization is not required, there is a waiting period of one week.)

4. *Hospital Benefit of $8 Per Day Paid If Hospital Charges Full Daily Rate:* The law previously denied a claimant his daily hospital benefit if he was confined in the hospital less than 24 hours even though he were charged a full daily rate by the hospital. The changed law provides for the payment of the $8 for each 24-hour period of hospitalization and, in addition, for any period of less than 24 hours for which an individual is charged the full daily rate.

5. *Assignment of Hospital Benefits:* Up to now, the Department of Employment could only pay benefits directly to a claimant. It is now allowed to make checks directly to hospital facilities if the claimant assigns his hospital benefits to a hospital.

6. *Hospital Benefits Not Allowable If Claimant's Hospitalization Is Furnished Under Workmen's Compensation Law or an Employer's Liability Law:* Payment of hospital benefits has been eliminated in those instances where hospital care is being furnished at no cost to the claimant because the hospital cost is covered under the Workmen's Compensation Law or an employer's liability law of this state or of any other state or of the federal government.

7. *Those Believing in Healing by Prayer or by Other Spiritual Means May Exempt Themselves from Contribution:* It was apparent that there was some unfairness in a law which compelled a person to contribute to a specific fund from which he would not be likely to draw benefits because of certain religious beliefs. Now, if such a person files a certification with his employer and the Department of Employment requesting an exemption from contribution, he is exempted from paying it.

8. *Benefits May Be Paid Claimant in Certain Instances Despite His Absence from Employment Because of a Trade Dispute:* Heretofore, if a claimant had left work primarily because of a trade dispute, he was ineligible to receive any disability benefits. Now, the law has been modified and provides for the payment of disability benefits to individuals when the proximate cause of wage loss is not directly attributable to the existence of a trade dispute. In other words, if the claimant's disability would have occurred and would have prevented him from continuing his work if the trade dispute had not occurred, if it was the result of an accident or required a period of hospitalization—if it was *not* caused by and did not arise out of the trade dispute—such claimant may receive disability benefits as otherwise provided by the act.

It should be pointed out that no change was made in the portion of the law controlling disabilities related to pregnancy. Although a number of proposals for changes were made, none was adopted. It is not considered a "disability" under the act if it is "caused by" or "arises in connection with" pregnancy unless the disability persists longer than four weeks after the termination of the pregnancy.

It is of interest to note that at present the number of workers covered is about equally distributed between private voluntary plans (either self insured or insurance companies) and the State Disability Fund. Furthermore, present estimates indicate that, out of every dollar paid for this insurance coverage by the workers, about 52 cents goes to private insurers and about 48 cents is paid into the state fund.

BOOK REVIEWS

DISEASES OF THE EAR, NOSE, AND THROAT—A Textbook of Clinical and Laboratory Procedures—Georges Portmann, M.D., Professor of Otorhinolaryngology at the University of Bordeaux; Surgeon at the Hospital of Tondu, Bordeaux; Surgeon at the Hospital Leopold Bellan, Paris; translated by Fernand Montreuil, M.D., and Jules G. Waltner, M.D., College of Physicians and Surgeons, Columbia University, New York. The Williams and Wilkins Company, Baltimore, 1951. 728 pages. $20.00.

The name Georges Portmann, M.D., is well known to all otolaryngologists. It is hoped that his text, Diseases of the Ear, Nose, and Throat, will be equally well known. The volume is a veritable storehouse of information. As a textbook, it is by far the most worthwhile and usable one that has been made available in several years. It should be considered as a necessary volume in the library of all otolaryngologists. Furthermore, it should be kept handy and available so that it will be read and reread as time and necessity permit or demand.

These statements are made with the full realization that there are parts of both the contents and context that offer themselves for question and argument. Some areas demand direct criticism. The seven-page introduction would have been excellent if it had stopped at the first half of page one. The remaining six and one-half pages devoted to ways and means of obtaining external illumination add nothing to the knowledge of those who are familiar with a head mirror and supply nothing of value for those who might wish to pursue this speciality. For those orderly-minded readers, who habitually start at page one and diligently carry on through to the last page, this introduction could easily prove to be a deterring factor. It is unfortunate that such an excellent volume should have such poor introduction.

The chapters on anatomy of the various organs are excellent. Unfortunately, as much cannot be said for some of the illustrations. A number of them are time-worn ones that have appeared in practically every volume of anatomy or textbook on this subject that has been presented during the last half-century. It is unfortunate that so many of the better anatomical illustrations were printed with their original French nomenclature. In a number of instances, the reader has to refer to the following page to find a supplemental translation. A number of the illustrations could have been deleted without detracting, in any way, from the advantages of visual education. Specifically, Figure 458, a rather poor drawing, depicting a bare, naked trachea, is devoid of all labeling, other than a major caption. In many instances, the subject matter selected for presentation in color is not good. The reproductions of the color illustrations are not good according to our present standards.

The chapters on physiology are entirely too short. Such material as is presented is well chosen, well selected, and is presented in a clear manner. Further elaboration on the applied physiology would add much to the interest factor as well as direct attention to the importance of obtaining and maintaining normal function.

Much time and space have been devoted to the reproduction of roentgenograms. A number of these films have lost so much in reproduction that the ultimate product does not present, to even the trained eye, sufficient detail to warrant the use of the space they occupy in the book. The chapter devoted to laboratory methods in otolaryngology is an unfortunate mixture of simple and involved procedures as well as a heterogeneous collection of semi-antique and modern methods. This chapter could be eliminated, or if retained, should be revised so as to be of real value.

These several criticisms have been presented in the hope that all who have the opportunity will read this volume carefully, and that these criticisms might act as a stimulation for this type of careful reading.

This review is presented with the idea of specifically recommending this textbook to all who are interested in the field of otolaryngology. The volume should be of some interest to the general practitioner and to the general surgeon. The present cost might seem to put it in the luxury class. The quality and caliber of the material presented is well worth the expenditure.

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RENAL PELVIS AND URETER—Peter A. Narath, M.D., F.I.C.S., Adjunct Professor of Urology, New York Polyclinic Medical School and Hospital. Grune and Stratton, New York, 1951. 429 pages. $12.50.

Narath's book is of great interest to the student of urology, whether he is still in the medical school or whether he has been practicing urology for many years. It is a capitulation of the scientific data related to the normal pelvis and ureter. It is exceedingly thorough and presents much that is original with the author.

The book is of a size that readily fits the hand, it is easy to read, with clear type printed on a good grade of paper. There are a large number of illustrations, many of them descriptive, and schematic drawings. Numerous pyelograms, which are, in most cases, well defined, depict the normal upper urinary tract and aid in explaining its anatomy and function.

There are chapters on the normal pelvis, its structure and histology. The dynamics of the upper urinary tract, together with the various aspects of absorption and resorption are dealt with in detail.

Anomalies and malformations and some aspects of the various types of extravasation are dealt with briefly, but, in general, there is a noticeable lack of discussion of the numerous pathologic changes which would seem to be natural for this book. Most physicians today, the reviewer included, consult a text of this type primarily for help in understanding or clearing up some puzzling pathologic condition. On the other hand, this book completely fulfills what it claims to be, a study of the normal upper urinary tract.

* * *

GROUPING, TYPING AND BANKING OF BLOOD—Otakar Jaroslav Pollak, M.D., Ph.D., F.A.C.P., Director, Blood Bank, Chief, Departments of Anatomical, Clinical and Experimental Pathology, Quincy City Hospital, Quincy, Mass. Charles C. Thomas, Publisher, 1951. 163 pp. $5.75.

Pollak's new book, "Grouping, Typing and Banking of Blood," fulfills the publisher's foreword, "The complex subject of immunohematology and the banking of blood are covered in simple language that will keep the reader's attention to the end."

This book contains only 163 pages; however, each page and each line is stripped of unessential detail, thereby giving the volume compactness of text, clarity of thought, and a progressive documentation of facts which make it a real joy to read.

Many authors might easily become swamped by minutiae when dealing with such intricate problems, tests and checks. Pollak, however, leads the reader to the next page in a most convincing but simple manner. I particularly liked his treatment of "Sources of error in blood grouping." It is a "must" for all who carry out such important work. The three chapters on "Blood Banks" follow the prevalent trend of thought, but they also sharpen the picture and bring into proper focus this most modern adjunct of medicine.

Every book has some minor faults. I cannot pass over the spelling of "saggital," page 78, or "irregardless," page 76, the latter a colloquialism and not considered good usage. I deplore the tendency to shorten the terms, "Rh positive" and "Rh negative" to "RH" and "rh." It may lead to some confusion of thought. I would rather Figure 22, page 108, not show the nurse clasping the dependent bottle with one hand and holding the venipuncture needle with the other. If a nurse did this for each donor she would soon complain of a most severe backache. I am sure most obstetricians will not like to read that "Usually the obstetrician will be interested in the blood type only." He certainly is vitally interested in the Rh factor, and avidly reads about this relatively new discovery. Most women patients have read about the Rh factor and their doctor, for self-protection, must answer their direct questioning. These minor faults fade into insignificance when one views and studies the entire book. The book should be placed on every laboratory and blood bank reading shelf. It bridges the hiatus between the old and new policies, and the new procedures have been tested, checked and found to be good.

The manual is especially useful during these days of international tension. "Blood is more valuable than bullets." Pollak's succinct teachings will aid our nation's technicians to draw blood properly, process it carefully, and administer it guardedly.

* * *

INTERNAL MEDICINE — Its Theory and Practice — Originally edited by John H. Musser, B.S., M.D., F.A.C.P., late Professor of Medicine, Tulane University of Louisiana School of Medicine; Fifth Edition by Michael G. Wohl, M.D., F.A.C.P., Associate Professor of Medicine, Temple University School of Medicine, Chief of Nutrition Clinic, Philadelphia General Hospital, Chief of Endocrine Clinic, Temple University Hospital. 80 contributors, 236 illustrations and 10 colored plates. Lea & Febiger, Philadelphia, 1951. 1,563 pages. $15.00.

The object of this book is to provide a comprehensive one-volume survey of internal medicine. To this end some 80 contributors (including more from California than the average text published today or yesterday has had) have aided Dr. Wohl in the revision and enlargement of Musser's *Textbook of Internal Medicine*. So many chapters have been rewritten and so many new ones added since the fourth edition, published in 1945, that it may be regarded as a new book.

The larger part of the book is conventional in its presentation. There are seven sections. The first deals with infectious disease; the second with diseases due to physical and chemical agents; the third with diseases of nutrition, metabolism and the endocrine glands; the fourth with the allergic and collagen diseases; the fifth with systemic diseases; and the seventh with diseases of the nervous system. Part IV is composed of two chapters; The Care of the Aged by Kern and Medical Practice and Rehabilitation by Rusk; the former is particularly trenchant. Together these two chapters give recognition to a part of medical practice which is growing rapidly and needs much expansion in teaching. (There is an unfortunate mistake in the table of contents where the sixth section is labeled V and the seventh section VI.)

The book is generally commendable. It is a good reliable general reference for internal medicine and will be valuable to internists, general practitioners and students alike. It contains a minimal amount of medical old wives' tales. While brought up close to the investigative level its general tone of advice is conservative.

Inevitably it must be compared with Harrison's *Principles of Internal Medicine*. Here it suffers somewhat in that the general presentation and outline of thought have not broken as completely with the past. Also the format and make-up are not as attractive or exciting. However, as a reference it appears equally trustworthy.

The reviewer finds various individual statements with which he might differ and a tendency in some of the chapters to pack the pages with information without adequate explanation—which makes for indigestible reading. Examples may be taken from the generally well-done section on Contagious Diseases of Childhood: the Pastia sign is explained as an increase in the erythema in the skin folds, whereas—in the next sentence—the Rumple Leede sign is not explained. The authors advise against routine prophylaxis with chemotherapy in scarlet fever. They also state that Dukes' (or Fourth) Disease is communicable for 28 days after the appearance of the rash.

The deficiencies are minor and do not alter our recommendation of this book for use as a text or reference.

* * *

ATLAS OF HISTOLOGIC DIAGNOSIS IN SURGICAL PATHOLOGY — Karl T. Neubuerger, M.D., Professor of Pathology, University of Colorado School of Medicine, Denver; with a section on Exfoliative Cytology by Walter T. Wikle, B.S., M.S., M.D., Assistant Professor of Pathology, University of Colorado School of Medicine, Denver; photography by Glenn E. Mills, B.A., M.A., Department of Visual Education, University of Colorado School of Medicine, Denver. The Williams and Wilkins Company, Baltimore, 1951, 460 pages, $11.00.

Anyone attempting the task of assembling an Atlas of Surgical Pathology is to be commended. Within the limitations of black and white photomicrography, Dr. Neubuerger has assembled an impressive volume of material tabulated by organs and organ-systems. The author's purpose is to present a semi-systematized ready-reference on the histopathology of surgical tissues together with a brief differential diagnosis, by utilizing 880 photomicrographs. The contents are limited to surgical pathologic material, presented specifically for students in the various specialties and subspecialties.

Despite the author's avowed purpose in providing "those who are preparing for the specialty boards" with "the characteristic illustration and differential diagnosis," the sections on eye and ear pathology are inadequate. In some instances the photomicrographs are too small and lacking in sufficient detail to be of much value.

Many tissue sections appear dark and shrunken, no doubt due to inherent technical difficulties. This is especially true of the low power fields. Most high-power illustrations, however, are indeed beautifully prepared. Several examples, notably "basosquamous carcinoma" (Fig. 77), "dermatopathic lymphadenopathy" (Fig. 95) and a few others might have been more carefully selected to better represent the characteristic features. Others, designated as "pigmented neurofibroma" (Fig. 55), "dystrophia myotomica" (Fig. 134), are unconvincing.

It is desirable for students to familiarize themselves with synonyms. Even though the author has limited the nomenclature to that in general usage, avoiding synonyms, the terms, "senile keratosis," "seborrheic keratosis" and "verruca senilis" are erroneously used interchangeably. Synonyms for others, such as *papillary cystadenoma lymphomatosum, carcinoid, cirrhosis* (i.e., type), *carcinoma of bile ducts*, might profitably have been included.

The section on thyroid is good, both in context and technical detail. Those on skin and subcutaneous tissues and also on the uterus are plentifully illustrated.

The last section on Exfoliative Cytology by Dr. W. T. Wikle, well illustrated by carefully selected examples of high technical quality is, perhaps, the outstanding feature of the book.

The book is handsomely bound. The paper is high quality, and is free of typographical errors.

PROGRAM AND PRE-CONVENTION REPORTS

for the

CALIFORNIA MEDICAL ASSOCIATION

Eighty-First Annual Session

Los Angeles, April 27—April 30, 1952

Biltmore Hotel

INDEX

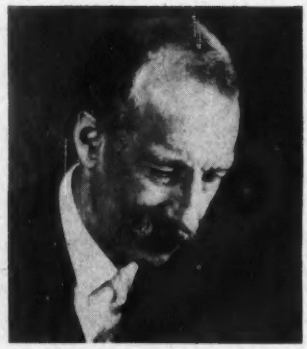
PRE-CONVENTION REPORTS

Guest Speakers

CHARLES L. BROWN

WILLIAM S. McCANN

LESTER R. DRAGSTEDT



HAVEN EMERSON

EUGENE P. PENDERGRASS

Guest Speakers

CHARLES L. BROWN, M.D., Philadelphia, Pennsylvania—Dean, Hahnemann Medical College.

WILLIAM S. MCCANN, M.D., Rochester, New York—Charles A. Dewey Professor of Medicine, University of Rochester School of Medicine.

LESTER R. DRAGSTEDT, M.D., Chicago, Illinois—Professor of Surgery, University of Chicago School of Medicine.

HAVEN EMERSON, M.D., New York, New York—Professor Emeritus, Public Health Administration, Columbia University College of Physicians and Surgeons; Past President, American Public Health Association.

EUGENE P. PENDERGRASS, M.D., Philadelphia, Pennsylvania—Professor of Radiology, University of Pennsylvania School of Medicine.

Other Section Speakers From Out of State

JAMES W. KERNOHAN, M.D., Rochester, Minnesota—Professor of Pathology, and Head of Section on Pathologic Anatomy and Neuropathology, Mayo Clinic. Guest of the Section on Pathology and Bacteriology.

EDITH L. POTTER, M.D., Chicago, Illinois—Associate Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago School of Medicine. Guest of Sections on Pediatrics and Dermatology and Syphilology.

WILLIS J. POTTS, M.D., Chicago, Illinois—Assistant Professor of Surgery, Northwestern University Medical School. Guest of the California Heart Association.

H. GORDON MacLEAN
President

LEWIS A. ALESEN
President-Elect

OFFICERS AND DELEGATES

General Officers

H. Gordon MacLean, Oakland, President
L. A. Alesen, Los Angeles, President-Elect
Donald A. Charnock, Los Angeles, Speaker of House of Delegates
Henry A. Randel, Fresno, Vice-Speaker of House of Delegates
Sidney J. Shipman, San Francisco, Chairman of Council
Albert C. Daniels, San Francisco, Secretary
Dwight L. Wilbur, San Francisco, Editor
John Hunton, San Francisco, Executive Secretary
Peart, Baraty & Hassard, Legal Counsel

Members of House of Delegates — 49th Annual Session

TOTAL DELEGATES (282)

DELEGATES EX OFFICIO (38)

H. Gordon MacLean, Oakland.....President
L. A. Alesen, Los Angeles.....President-Elect
Donald A. Charnock, Los Angeles.....Speaker of House of Delegates
Henry A. Randel, Fresno.....Vice-Speaker of House of Delegates
Albert C. Daniels, San Francisco.....Secretary-Treasurer
Dwight L. Wilbur, San Francisco.....Editor
Francis E. West (1952).....Councilor 1st District
*John D. Ball (1953).....Councilor 2nd District
H. Clifford Loos (1954).....Councilor 3rd District
J. Philip Sampson (1952).....Councilor 4th District
A. A. Morrison (1953).....Councilor 5th District
Neil J. Dau (1954).....Councilor 6th District
Hartzell H. Ray (1952).....Councilor 7th District
M. Laurence Montgomery (1953).....Councilor 8th District
Donald D. Lum (1954).....Councilor 9th District
John W. Green (1952).....Councilor 10th District
Wayne E. Pollock (1953).....Councilor 11th District
Benjamin Frees (1952).....Councilor-at-Large
C. V. Thompson (1952).....Councilor-at-Large
Sidney J. Shipman (1953).....Councilor-at-Large
Wilbur Bailey (1953).....Councilor-at-Large
Arthur E. Varden (1954).....Councilor-at-Large
Ivan C. Heron (1954).....Councilor-at-Large

ELECTED DELEGATES (244)

Delegates	*Alternates*
Alameda-Contra Costa County (20)	
Dorothy M. Allen	Helen Jean Snook
Cyril J. Attwood	Homer S. Fornoff
J. C. Bartlett	Grant Ellis
Philip N. Baxter	James C. Raphael
K. W. Benson	George S. Irvine
John Blum	Robert L. Redfield
A. Bradford Carson	Melvin G. Hart
William G. Donald	Rolland A. Crum
Thomas J. Dozier	Ralph M. Bell
L. H. Fraser	Kaho Daily
Bernard B. Gadwood	Paul H. Ryan
James B. Graeser	David J. Dugan
Ernest W. Henderson	Paul R. Shumaker
Lester Lawrence	Dan Tucker
Robert S. Leet	William Kaiser
H. P. Maloney	Thomas T. Rolleri
Joseph L. Marriott	Bruce Stephens
T. E. Reynolds	C. G. Furbush
Douglas Toffelmier	C. J. Lunsford
Stanley R. Truman	H. C. Crockett
Butte-Glenn County (2)	
Hollis L. Carey	C. E. Plumb
C. Meredith Guernsey	Donald Casey
Fresno County (5)	
R. W. Dahlgren	R. J. van Wagenen
Verne Ghormley	Elmer Hof
E. C. Halley	H. M. Ginsburg
Eliot Sorsky	Robb Smith
J. E. Young	A. F. Howard
Humboldt County (2)	
Wayne P. McKee	Max J. Goodman
O. R. Myers	Herbert L. Moore
Imperial County (2)	
Charles M. Cutshaw	George C. Holleran
Frederick Powers Heald	E. H. Benson
Inyo-Mono County (2)	
C. C. Curtis	J. Lloyd Mason
C. L. Scott	George D. Schultz
Kern County (2)	
Robert A. Patrick	Robert Douds
J. E. Vaughan	Carl L. Moore
Kings County (2)	
W. S. Bridwell	J. P. Young
William F. Chamlee	Lloyd Christensen
Lassen-Plumas-Modoc County (2)	
E. I. Burnett	Philip W. McKenney
A. E. Priest	Roy M. Peters
Los Angeles County (92)	
E. Vincent Askey	John D. Abbey
Elmer J. Ball	Lawrence Adams
Franklin L. Ball	H. Edward Beaghler
Madelene Beckenbach	Herbert J. Andrews
A. Elmer Belt	Brigham J. Bergstrom
Frederic K. Bergstrom	Daniel Beltz
John W. Beswick	Vernon W. Foster
Walter H. Boyd	Walter Buerger
Alva L. Bryant	Arthur T. Bailey
Richard O. Bullis	Fred E. Bradford
Behle B. Burns	Robert G. Freeman
L. C. Burwell	James L. Bray
Tenero D. Caruso	John A. Bullis
Donald Cass	Rafe C. Chaffin
Orville W. Cole	John Thomas Hardesty
Wells C. Cook	Harold E. Crowe
Clair P. Cosgrove	Leon O. Desimone
Jay B. Cosgrove	Wells E. A. Forde
William E. Costolow	Garland F. Garrett
Charles H. Cowgill	Merwin R. Chappel
Lyle G. Craig	
Frank G. Crandall, Jr.	Frederic J. Gaspard
Edward H. Crane, Jr.	David J. Brobeck
Jay J. Crane	Francis E. Guinney
Verne C. Crowl	Thomas R. Kidd
Philip J. Cunnane	Alfred G. Henrich
Rynol A. Dahlman	William D. Evans
M. A. Desmond	Ruth Appleby
Harry F. Dietrich	James C. Doyle

* Deceased.

Delegates	*Alternates*
John W. Dorsey	Robert Helms
Frederic Ewens	F. C. Westerhout
Gaylord Fisher	Walter P. Martin
Paul D. Foster	Wybren Hiemstra
Mark Giffords	John E. Bergmann
Willard M. Gobbell	T. J. Laughlin
William E. Graham	Charles V. Emerson
Robert B. Haining	Elizabeth Mason Hohl
Dorothy Hewitt	Irving Rosenberg
John W. Higgins	Victor E. Hallstone
Eugene F. Hoffman	Robert B. Hope
Howard P. House	Willis L. Jacobus
Carl R. Howson	George E. Judd
Louis L. Huff	Charles T. Poulson
Arthur H. Hurd	Donald D. Parker
John B. James	Peter H. Blong
Fordyce Johnson	Robert M. Shelton
Bennett W. Kantola	George E. Bien
Joel S. Kelsey, Jr.	Alexander A. Mueller
Arthur A. Kirchner	George P. Landegger
George L. Kraft	Thomas A. LeValley
E. R. Lambertson	Grant H. Lanphere
Arthur John Langan	Jesse L. Bloch
William H. Leake	Lewis F. Ellmore
Karl Lewis	M. Coleman Harris
J. Lafe Ludwig	F. E. Leffingwell
Wellesley P. Magan	Milton R. Jones
Russell W. Mapes	Clement J. Molony
John B. Marr	
Angus McDonald	Paul E. Travis
James J. Morrow	John E. Miracle
Carl L. Mulfinger	Douglas R. MacColl
Maurice N. Nugent	June P. McBride
Joseph P. O'Connor	Charles W. Ware
J. Norman O'Neill	Edwin E. McNiel
Frank W. Otto	Robert W. Meals
John R. Paxton	Marden A. Alsberge
Merl Lee Pindell	Roderick M. Neale
Myron Prinzmetal	Morton H. Randall
Hubert J. Prichard	Malcolm Todd
James F. Regan	Edward F. Nippert
E. T. Remmen	Reid L. Beers
J. M. de los Reyes	Edward C. Pallette
Gordon L. Richardson	Karl P. Stadlinger
Edward C. Rosenow, Jr.	Lawrence A. Williams
Eric A. Royston	Ross V. Parks
John C. Ruddock	Edwin B. Plimpton
Ralph L. Schroeder	Robert A. Lovell
Arthur H. Schwartz	Fred Schlumberger
Walter Scott	William F. Quinn
J. Edward Short	Ward M. Rolland
Ralph Varian Sloan	Eugene J. Joergenson
Elvin H. Stanton	Bruce E. Roesler
Justin J. Stein	Gordon K. Smith
G. Arnold Stevens	Robert Simonds
Clinton H. Thienes	William H. Snyder
Ewing L. Turner	Norman F. Sprague, Jr.
H. Milton Van Dyke	George G. Verbryck
John O. Vaughn	Bernard H. Smith
E. E. Wadsworth, Jr.	Leon R. Walker
Warren A. Wilson	Packard Thurber, Jr.
Harold R. Witherbee	John W. Whitsett
William T. Zimmermann	J. Walter Wilson
Madera County (2)	
Gilbert Daggett	Omar Need
Gordon Diddy	
Marin County (2)	
Edward Campion	Arnold Nutting
William B. Smith	Leo L. Stanley
Mendocino-Lake County (2)	
Thomas P. Hill	J. E. Gardner
Robert Smalley	Royal Scudder
Merced County (2)	
E. A. Jackson	Shelby Hicks
George Pimentel	A. B. Bigler
Monterey County (2)	
J. B. McCarthy	Howard C. Miles
James H. McPharlin	Allen C. Mitchell
Napa County (2)	
Dale E. Barber	H. B. Messinger
George I. Dawson	Walter H. Brignoli
Orange County (4)	
A. Norton Donaldson	Harold Galbraith
Arthur J. Nies	William Owen
J. B. Price	Samuel Gendel
L. E. Wilson	Milton Maxwell
Placer-Nevada-Sierra County (2)	
Harry March	Saul Ruby
William M. Miller	Max Dunievitz

Delegates	*Alternates*
Riverside County (2)	
H. M. F. Behneman	Walter J. Wood
Franklin B. Mead	C. P. McCullough
Sacramento County (5)	
Dave F. Dozier	Frank W. Lee
A. M. Henderson, Jr.	E. E. Simpson
Dudley Saeltzer	Charles E. Grayson
Milton V. Sarkisian	James H. Yant
Ralph Teall	Dan O. Kilroy
San Benito County (2)	
John J. Haruff	E. N. Moore
Eberle Sheldon	R. E. Brown
San Bernardino County (5)	
C. Norman Abbott	Frank C. Melone
John H. Coughlin	Joseph S. Hayhurst
Carl M. Hadley	Roger A. Vargas
J. Needham Martin	Gordon L. Helstrom
E. L. Tisinger	Charles J. Clock
San Diego County (10)	
Douglass H. Batten	Ralph M. King
Hall G. Holder	Walter F. Carpenter
Roger C. Isenhour	James W. Ravenscroft
Arthur A. Marlow	Roy A. Ouer
A. E. Moore	Joseph M. Maguire
Willard H. Newman	James R. Phalen
James G. Omelvena	Frank H. Robinson
Clarence E. Rees	James I. Knott
John M. Rumsey	W. T. Soldmann, Jr.
Joseph W. Telford	Calvin L. Stewart
San Francisco County (29)	
Dorothy W. Atkinson	Frank Norris
Walter Beckh	Roy B. Cohn
William L. Bender	A. B. Sirbu
William G. Burkhard	Henry B. Woo
George Campion	Agnes G. Plate
Garnett Cheney	Gerald G. Gill
Frederick A. Fender	James H. Thompson
Kenneth D. Gardner	Leon O. Parker
L. Henry Garland	August Reich
Henry Gibbons, III	Roberta F. Fenlon
Harold M. Hand	Arthur Collis Gibson
Alson R. Kilgore	Reuben H. Zumwalt
Russell R. Klein	Emile D. Torre
Carleton Mathewson, Jr.	Donald M. Campbell
Joseph S. McGuinness	Walter W. Port
Stacy R. Mettier	Wm. W. Washburn
Herbert C. Moffitt, Jr.	Don Lastreto
Edmund J. Morrissey	Mary B. Olney
Lowell A. Rantz	Paul S. Wyne
Francis Rochex	Vance M. Strange
William L. Rogers	Harry Weinstein
Robert A. Scarborough	Mary E. Mathes
Samuel R. Sherman	Lawrence M. Trauner
Francis A. Sooy	Robert C. Combs
August Spitalny	Curtis E. Smith
Grace M. Talbott	Forrest M. Willett
Huldah E. Thelander	Theodore Paoli
Robertson Ward	Douglas G. Campbell
Helen B. Weyrauch	Donald A. Carson
San Joaquin County (3)	
J. Frank Doughty	Neill P. Johnson
Jack Eccleston	L. P. Armanino
George K. Wever	F. A. McGuire
San Luis Obispo County (2)	
Charles R. Kennedy	George K. Dunklee
Robert O. Pearman	Albert Gazin
San Mateo County (5)	
James S. Edwards	Charles D. Armstrong
Thomas E. Farthing	Carl Benninghoven
Logan Gray	Bradley C. Brownson
A. G. Miller	Alf T. Haerem
Frederic P. Shidler	George J. Laird
Santa Barbara County (3)	
J. Gary Campbell	Hugh F. Freidell
Lawrence M. Nelson	L. K. Thacher
Alfred B. Wilcox	David L. Reeves
Santa Clara County (7)	
Burt Davis	George B. Armanini
Thomas N. Foster	Ansten R. Ness
Leon P. Fox	George Waters
J. B. Josephson	J. D. Lamon, Jr.
Leslie B. Magoon	Lee Blanchard
William L. Molineux	Sydney Thomas
Paul V. Morton	J. Frederick Snyder

Delegates	*Alternates*
Santa Cruz County (2)	
Luther Newhall	
Samuel B. Randall	J. A. Ludden
Shasta County (2)	
Roland R. Jantzen	Joe L. Price
George A. Martin	Alex J. Otten
Siskiyou County (2)	
James B. McGuire	Eugene V. Anderson
Albert H. Newton	Harry L. Vidricksen
Solano County (2)	
John Garthe	Felix Rossi
Lionel Johnson	F. Burton Jones
Sonoma County (2)	
John J. Mohrman	Leonard W. Hines
Horace F. Sharrocks	Donovan C. Oakleaf
Stanislaus County (2)	
George S. Feher	O. D. Ellefson
Edward K. Prigge	M. C. Collins
Tehama County (2)	
R. G. Frey	A. H. Meuser
James T. McDuffie	O. T. Wood

Delegates	*Alternates*
Tulare County (2)	
J. H. Brady	Wiley C. Zink
James E. Feldmayer	C. H. Johnson
Ventura County (2)	
Franklin K. Helbling	Gerald K. Ridge
J. W. Moore	Woodrow W. Schmela
Yolo County (2)	
Robert A. Burns	John G. O'Hara
Ray E. Nichols	Thomas Y. Cooper
Yuba-Sutter-Colusa County (2)	
Stanley R. Parkinson	Joseph J. Salopek
Francis P. Wisner	Charles B. Kimmel

Past Presidents (15)

George H. Kress	1916
Edward N. Ewer	1925
Lyell C. Kinney	1930
Junius B. Harris	1931
George G. Reinle	1933
Robert A. Peers	1935
Harry H. Wilson	1940
William R. Molony, Sr.	1942
Karl L. Schaupp	1943
Lowell S. Goin	1944
Sam J. McClendon	1946
John W. Cline	1947
E. Vincent Askey	1948
R. Stanley Kneeshaw	1949
Donald Cass	1950

House of Delegates Agenda

1952 Annual Session

Music Room, Biltmore Hotel

Speaker, DONALD CHARNOCK, *Los Angeles*
Vice-Speaker, HENRY A. RANDEL, *Fresno*
Secretary, ALBERT C. DANIELS, *San Francisco*

FIRST MEETING
Sunday, April 27, 1952 at 9:30 a.m.

ORDER OF BUSINESS

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (a) Committee on Credentials. (Delegates must register with the Committee.)
   (b) Reference Committee on the Reports of Officers, the Council and Standing and Special Committees. (Reference Committee No. 1.)
   (c) Reference Committee on Finance, to review the reports of the Secretary-Treasurer and the Executive Secretary and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year (Reference Committee No. 2).
   (d) Reference Committee on Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business (Reference Committee No. 3).
   (e) Reference Committee on Executive Session, to consider business brought before the House of Delegates in Executive Session. (Reference Committee No. 4.)
5. Address by President H. Gordon MacLean. Presentation of 50-Year Awards.
6. Miscellaneous announcements by the Speaker. (Stenographic service, to secure triplicate copies of resolutions, etc.)
7. Report of the President—H. Gordon MacLean.
8. Report of the President-elect—L. A. Alesen.
9. Report of the Speaker of the House of Delegates—Donald Charnock.
10. Report of the Vice-Speaker—H. A. Randel.
11. Report of the Council—Sidney J. Shipman.
12. Report of the Chairman of the Executive Committee—Donald D. Lum.
13. Report of the Trustees of the California Medical Association—H. Gordon MacLean, president.
14. Report of the Secretary—Albert C. Daniels.
15. Report of the Executive Secretary—John Hunton.
16. Report of the Editor—Dwight L. Wilbur.
17. Reports of District Councilors.
18. Reports of Councilors-at-Large.
19. Report of Legal Counsel—Peart, Baraty & Hassard.
20. Reports of Standing and Special Committees:
   A. Standing Committees:
   (a) Executive Committee—Donald D. Lum.
   (b) Committee on Associated Societies and Technical Groups—Robert A. Scarborough.
   (c) Auditing Committee—Donald D. Lum.
   (d) Committee on History and Obituaries—Dewey R. Powell.
   (e) Committee on Hospitals, Dispensaries, and Clinics—John B. Hamilton.
   (f) Committee on Industrial Practice—Jerome Shilling.
   (g) Committee on Medical Defense—H. Clifford Loos.
   (h) Committee on Medical Economics—Arthur A. Kirchner.
   (i) Committee on Medical Education and Medical Institutions—Francis Scott Smyth.
   (j) Military Affairs and Civil Defense—Justin J. Stein.
   (k) Physicians' Benevolence Committee—Axcel E. Anderson.
   (l) Committee on Postgraduate Activities—Edward C. Rosenow, Jr.
   (m) Committee on Public Policy and Legislation—Dwight H. Murray.
   (n) Committee on Public Relations—Ed Clancy.
   (o) Committee on Scientific Work (Annual Session)—Albert C. Daniels.
   (p) Cancer Commission—Robert A. Scarborough.
   (q) Editorial Board—Dwight L. Wilbur.
   B. Special Committees:
   (a) Delegates to the American Medical Association—E. Vincent Askey.
   (b) Advisory Planning Committee—John Hunton.
   (c) Blood Bank Commission—John Upton.
   (d) C.P.S. Liaison Committee—H. Gordon MacLean.
   (e) C.P.S. Study Committee—Wilbur Bailey.
   (f) Committee on Industrial Health—Christopher Leggo.
   (g) Committee on Rural Medical Service—Henry A. Randel.
   (h) C.P.S. Fee Schedule Committee—DeWitt K. Burnham.
21. Old and Unfinished Business.
22. New Business.

SECOND MEETING

Tuesday, April 29, at 9:30 a.m.

ORDER OF BUSINESS

1. Call to order.
2. Supplemental report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1953 annual session.
5. Election of Officers:
   (a) President-elect.
   (b) Speaker.
   (c) Vice-Speaker.
   (d) District Councilors (three-year term):
      1. First District—Francis E. West, San Diego (term expiring).
         First District—San Diego County.
      2. Second District—John D. Ball, Santa Ana (deceased)—for term expiring 1953.
         Second District—Imperial, Inyo, Mono, Orange, Riverside and San Bernardino counties.
      3. Fourth District—J. Philip Sampson, Santa Monica (term expiring).
         Fourth District—Los Angeles County.
      4. Seventh District—Hartzell H. Ray, San Mateo (term expiring).
         Seventh District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz counties.
      5. Tenth District—John W. Green, Vallejo (term expiring).
         Tenth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano and Sonoma counties.
   (e) Councilors-at-Large (three-year terms):
   Benjamin Frees, Los Angeles (term expiring).
   C. V. Thompson, Lodi (term expiring).
   (f) Delegates to American Medical Association:
   Delegates and Alternates to the American Medical Association are elected for terms of two calendar years. The Delegates and Alternates to be elected at this meeting will serve for two calendar years ending December 31, 1954.
   Incumbents:
   (a) H. Gordon MacLean, Oakland (term expiring).
   (b) E. Vincent Askey, Los Angeles (term expiring).
   (c) Dwight L. Wilbur, San Francisco (term expiring).
   (d) Donald Cass, Los Angeles (term expiring).
   (e) Ralph B. Eusden, Long Beach (term expiring).
   (f) R. Stanley Kneeshaw, San Jose (term expiring).
   (g) Alternates to American Medical Association:
   Incumbents:
   (a) Leopold H. Fraser, Richmond (alternate to H. Gordon MacLean).
   (b) H. Clifford Loos, Los Angeles (alternate to E. Vincent Askey).
   (c) C. Kelly Canelo, San Jose (alternate to Dwight L. Wilbur).
   (d) L. Duke Mahannah, Long Beach (alternate to Donald Cass).
   (e) J. Lafe Ludwig, Los Angeles (alternate to Ralph B. Eusden).
   (f) Russel V. Lee, Palo Alto (alternate to R. Stanley Kneeshaw).
   (g) John D. Ball, deceased (alternate to L. A. Alesen)—for term expiring December 31, 1953.
6. Election of two members to C.M.A.-C.P.S. Liaison Committee.
7. Announcement by Secretary.
   Council's nominations of members of Standing Committees (for approval by the House of Delegates).
8. Reports of Reference Committees:
   (a) Report of Reference Committee No. 1 on Reports of Officers, the Council, and standing and Special Committees.
   (b) Report of Reference Committee No. 2 on Reports of the Secretary-Treasurer and the Executive Secretary, on budget and dues.
   (c) Report of Reference Committee No. 3 on Resolutions, Amendments to the Constitution and By-Laws and New and Miscellaneous Business.
   (d) Report of Reference Committee No. 4 on business brought before the House of Delegates in Executive Session.
9. Unfinished Business.
10. New Business.
11. Presentation of Officers:
    President
    President-Elect
    Speaker
    Vice-Speaker
12. Presentation of Certificate to Retiring President—H. Gordon MacLean.
13. Approval of Minutes. (Committee to edit.)
14. Adjournment.

DONALD A. CHARNOCK, *Speaker*
ALBERT C. DANIELS, *Secretary*

* * * * * * *

Meeting of C.P.S. Administrative Members

April 27, 1952

AGENDA

1. Roll Call.
2. Report of the President: Donald Cass, M.D.
3. Report of Committee of Eight (Fee Schedule Committee).
4. Announcement of Nominating Committee.
5. Announcement of Resolutions Committee.
6. Introduction of Resolutions.
7. Recess (48 hours).

SECOND MEETING

1. Roll Call.
2. Consideration of report of Nominating Committee.
3. Consideration of resolutions and report of Resolutions Committee.
4. New business.

Old Business

PROPOSED CONSTITUTIONAL AMENDMENTS

Printed here for the second time are the proposed amendments to the Constitution of the California Medical Association that were introduced at the 1951 Annual Session, and that are to be acted upon by the House of Delegates at the 1952 meeting.

Submitted by Donald Carson, San Francisco:

Resolved, That subparagraph (c) of Section 9, Part B, of Article III of the Constitution be amended to read as follows:

(c) The President, President-Elect, Speaker and Vice-Speaker.

* * *

Submitted by E. T. Remmen, Los Angeles:

Be It Resolved, That Article III, Part A, Section 1 of the Constitution be amended to read as follows:

The House of Delegates shall consist of

(a) Delegates elected by the members of component societies as provided in the By-Laws;

(b) Officers of the Association, as designated in Article VI, Section 1 of this Constitution. Excepting the Secretary-Treasurer and the Editor, they shall have the right to vote.

Anything in the Constitution and By-Laws which is in conflict with the foregoing is hereby repealed.

* * *

Submitted by E. T. Remmen, Los Angeles:

Be It Resolved, That Article III, Part B, Section 11* of the Constitution be amended to read as follows:

(a) District Councilors shall be elected by vote of the delegates from each district in the manner and at the time specified in the By-Laws.

Paragraph (b) is hereby repealed, except that the present Councilors-at-Large shall complete their terms.

Anything in the Constitution and By-Laws in conflict with the foregoing is hereby repealed.

*Due to a typographical error, this amendment was introduced as applying to Article III, Part B, Section 9, whereas it is obvious that the author intended it to apply to Section 11.

Submitted by E. T. Remmen, Los Angeles:

Be It Resolved, That Article III, Part B, Section 9 of the Constitution shall be amended to read as follows:

The Council shall consist of:

(a) Eleven District Councilors elected from the Councilor districts specified in this Constitution.

(b) The President, President-Elect and Speaker. In addition the Secretary-Treasurer and Editor, but without the right to vote.

Anything in the Constitution and By-Laws which is in conflict with the foregoing is hereby repealed.

* * *

Submitted by E. T. Remmen, Los Angeles:

Be It Resolved, That Article IV, Section 5 of the Constitution be amended to read as follows:

At each regular session of the House of Delegates, the Council shall submit to it an itemized budget stating the proposed expenditures of the Association for the ensuing year. The budget may be altered or revised by the House of Delegates, but must be adopted by the House before adjournment of the session. After its adoption, no expenditures in excess of the amount of the budget item covering the subject of such expenditures may be made in the year covered by the budget by the Association or any of its officers, agents or employees, unless the Council by a three-fourths vote of all voting members shall first approve such excess expenditure by resolution duly adopted, and further provided that in no instance may the Council expend funds in any fiscal year in excess of 25 per cent more than the total amount of the budget without permission of the House of Delegates. Recurring items in the budget (fixed expenditures covering more than one year) shall, when first adopted, be binding as to the subsequent budgets to the extent of commitments or obligations entered into by the Association within authority granted by the House of Delegates or this Constitution or the By-Laws.

SCIENTIFIC SESSIONS

General Meetings

FIRST GENERAL MEETING

SUNDAY, APRIL 27

3:00—Biltmore Theatre

Chairman: H. Gordon MacLean, M.D., Oakland

3:00—**Address of Welcome**—Wilbur Bailey, M.D., President, Los Angeles County Medical Association.

3:05—**Greetings from the Woman's Auxiliary**—Mrs. Stanley R. Truman, President Woman's Auxiliary to the California Medical Association.

3:10—**Address of the President**—H. Gordon MacLean, M.D., Oakland.

3:40—**Changing Concepts in Medical Treatment**—Charles L. Brown, M.D., Philadelphia, Pennsylvania, by invitation.

4:10—**The Meaning of Disease**—William S. McCann, M.D., Rochester, New York, by invitation.

4:40—**The Physiology of Gastric Secretion and the Ulcer Problem**—Lester R. Dragstedt, M.D., Chicago, Illinois, by invitation.

SECOND GENERAL MEETING

MONDAY, APRIL 28

2:00—Biltmore Theatre

Chairmen: William P. Longmire, Jr., M.D., Los Angeles
Edgar Frank Mauer, M.D., Los Angeles

2:00—**Medical Care and Public Health Service**—Haven Emerson, M.D., New York, New York, by invitation.

2:30—**The Role of the Radiologist in Diagnosis of Chest Lesions**—Eugene P. Pendergrass, M.D., Philadelphia, Pennsylvania, by invitation.

3:00—**Question and Answer Period.**

Clinical-Pathological Conference

3:15—**Case No. 1**—Pathologist Charles P. Baker, M.D., Oakland. Surgeon Lester R. Dragstedt, M.D., Chicago, Illinois, by invitation. Radiologist Eugene P. Pendergrass, M.D., Philadelphia, Pennsylvania, by invitation.

4:00—**Case No. 2**—Pathologist Fremont E. Davis, M.D., Alhambra. Clinician William S. McCann, M.D., Rochester, New York, by invitation.

EMERGENCY CALLS

Notify your office or exchange regarding the meetings you plan to attend. In cases of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, DUnkirk 7-7175; Sunday and evenings after 5:00 p.m., DUnkirk 7-8141.

Section Meetings

GENERAL MEDICINE

Edgar Frank Mauer, M.D., Los Angeles, *Chairman*
J. Malcolm Stratton, M.D., Berkeley, *Secretary*
William D. Evans, M.D., North Hollywood, *Assistant Secretary*

EDGAR FRANK MAUER
Chairman

J. MALCOLM STRATTON
Secretary

MONDAY, APRIL 28

9:30—Auditorium, Sunkist Building

Joint Meeting with Sections on General Surgery and Radiology

For Program, see Section on General Surgery

TUESDAY, APRIL 29

9:30—Auditorium, Sunkist Building

9:30—Rheumatic and Congenital Heart Disease—Some Statistical Findings—A. F. Goggio, M.D., Berkeley.

9:40—Phenylbutazone and Related Compounds in the Treatment of Rheumatic Disease—William C. Kuzell, M.D., and Ralph W. Schaffarzick, M.D., San Francisco.

9:50—Newer Hematinics, Their Use and Abuse—William F. Luttgens, M.D., San Francisco.

10:05—New Therapy for Leukemia, Polycythemia and Lymphoma—Arthur A. Marlow, M.D., La Jolla.

10:20—Indications for Splenectomy—S. P. Lucia, M.D., San Francisco.

10:35—Effects of Compound F in Rheumatoid Disease—Edward F. Boland, M.D., Los Angeles.

10:55—Intermission.

11:00—Problems in the Treatment of Virus Pneumonia—Morris F. Collen, M.D., Oakland.

11:15—Coxsackie Viruses and Their Epidemicity—Charles M. Carpenter, M.D., Los Angeles; Ruth A. Boak, M.D., Los Angeles, by invitation.

11:30—Adventures in the Study of Breathing—William S. McCann, M.D., Rochester, N. Y., by invitation.

11:55—Annual Meeting—California Society of Internal Medicine.

WEDNESDAY, APRIL 30

9:30—Auditorium, Sunkist Building

9:30—Thyroxin Synthesis Measured with Radioactive Iodine in the Evaluation of Equivocal States of Thyroid Function—M. E. Morton, M.D., Long Beach, by invitation.

9:45—The Diagnosis of Morphologic Abnormalities of the Human Thyroid Gland by Means of I^{131}—Franz K. Bauer, M.D., Los Angeles.

10:00—Diabetic Retinitis—Its Control—J. W. Sherrill, M.D., La Jolla.

10:15—Panel Discussion—What is the Ideal Level of Diabetic Control?

Moderator: Helen E. Martin, M.D., Los Angeles.

Panel: Charles L. Brown, M.D., Philadelphia, Pa., by invitation; J. W. Sherrill, M.D., La Jolla; Douglas Drury, M.D., Los Angeles, by invitation; and G. B. Robson, M.D., San Francisco.

10:40—Intermission.

10:45—**Relationship of Diet to the Correlation of Serum Cholesterol and Lipoprotein with Clinical Atherosclerosis** — John Gofman, M.D., Berkeley, by invitation.

11:00—**Controlled Experimental Observations on the Relationship of Serum Lipids in Normal and Abnormal Subjects**—Lawrence Kinsell, M.D., Oakland.

11:15—Discussion.

11:25—**Business Meeting and Election of Officers.**

11:30—**Two Kinds of Death**—William S. McCann, M.D., Rochester, N. Y., by invitation.

WEDNESDAY, APRIL 30

1:30—Music Room, Biltmore Hotel

Cardiac Surgery

This program has been arranged jointly by the California Heart Association and the Section on General Medicine

Chairmen: Francis L. Chamberlain, M.D., President, California Heart Association
Edgar F. Mauer, M.D., Chairman, Section on General Medicine

1:30—**Problems in Anesthesia During Cardiac Surgery**—Judson S. Denson, M.D., Los Angeles.

1:45—**Abnormal Cardiac Findings Occurring During Cardiac Surgery**—Harold Miller, M.D., Los Angeles, by invitation.

2:05—**Cardiac Resuscitation** — Sanford E. Leeds, M.D., San Francisco.

2:25—**Clinical Experiences with Vascular Anomalies of the Aortic Arch**—Paul C. Samson, M.D., Oakland.

2:45—**Recent Advances in the Surgery of Large Arteries** — Norman E. Freeman, M.D., San Francisco.

3:05—**Intermission.**

3:20—**Anomalous Drainage of the Pulmonary Veins** —H. Brodie Stephens, M.D., San Francisco.

3:40—**Surgical Aspects of Pulmonary Stenosis**—B. W. Meyer, M.D., Los Angeles.

4:00—**Surgical Aspects of Mitral Stenosis**—John C. Jones, M.D., Los Angeles.

4:20—**Surgery of Cyanotic Heart Disease**—Willis J. Potts, M.D., Chicago, Illinois, by invitation.

Bring Proper Identification for Registration

GENERAL SURGERY

William P. Longmire, Jr., M.D., Los Angeles, *Chairman*
Paul C. Samson, M.D., Oakland, *Secretary*
Arthur C. Pattison, M.D., Pasadena, *Assistant Secretary*

WILLIAM P. LONGMIRE, JR.
Chairman

PAUL C. SAMSON
Secretary

MONDAY, APRIL 28

9:30—Auditorium, Sunkist Building

Joint Meeting with Sections on General Medicine and Radiology

Symposium

Diseases of the Pancreas

9:30—Adenoma of the Islets of Langerhans—James H. Saint, M.D., Santa Barbara.

9:45—The Clinical Picture of Pancreatic Insufficiency—Charles L. Brown, M.D., Philadelphia, Pennsylvania, by invitation.

10:10—Roentgen Diagnosis of Diseases of the Pancreas—Eugene P. Pendergrass, M.D., Philadelphia, Pennsylvania, by invitation.

10:35—Pathological and Physiological Correlations in Various Diseases of the Pancreas—Hugh A. Edmondson, M.D., Los Angeles.

10:55—Some Technical Considerations in Relation to Surgery of the Pancreas—Carleton Mathewson, M.D., San Francisco.

11:15—Some Physiologic Problems Involved in the Surgery of the Pancreas—Lester R. Dragstedt, M.D., Chicago, Illinois, by invitation.

11:40—Round Table Discussion

Moderator: William P. Longmire, Jr., M.D.

Members of Panel: Charles L. Brown, M.D., Lester R. Dragstedt, M.D., Hugh A. Edmondson, M.D., Carleton Mathewson, M.D., and Eugene P. Pendergrass, M.D.

TUESDAY, APRIL 29

9:30—Auditorium, Southern California Edison Building

9:30—Chairman's Address: A Review of Surgery of the Adrenal Glands—William P. Longmire, Jr., M.D., Los Angeles.

9:50—Repair of Strictures of the Bile Duct by the Transduodenal Route—Lester R. Dragstedt, M.D., Chicago, Illinois, by invitation.

10:10—Statistical Report on Tumors of the Endocrine Glands, Reported by Hospitals Participating in the California Central Tumor Registry—James W. Ellis, M.D., Lester Breslow, M.D., Berkeley, and Martha Simmons, S.C.M., Berkeley, by invitation.

Discussion.

10:30—Prevention of Surgical Complications—Suren H. Babington, M.D., Berkeley.

Discussion.

10:50—Surgical Treatment of the Postphlebitic Leg—Harold P. Totten, M.D., Inglewood.

Discussion.

11:10—Recurring Breast Abscesses in the Areolar Area—Alson R. Kilgore, M.D., and Ruth Fleming, M.D., San Francisco.

Discussion.

11:30—Is Radical Mastectomy Still the Preferred Treatment in Operable Breast Cancer?—Harry E. Peters, Jr., M.D., Oakland.

Discussion.

11:50—Routine Gastroduodenostomy After Gastric Resection—R. L. Zieber, M.D., and J. M. Kenney, M.D., Santa Rosa.

Discussion.

12:10—**Annular Pancreas — Late Postoperative Sequelae**—Alfred J. Goldyne, M.D., and Everett Carlson, M.D., San Francisco.

WEDNESDAY, APRIL 30

9:30—Auditorium, Southern California Edison Building

9:30—**Diaphragmatic Herniation Through the Space of Morgagni**—Donald F. Rowles, M.D., Oakland, by invitation, and Gerald L. Crenshaw, M.D., Oakland.

Discussion.

9:50—**Mediastinal Tumors of Thymic Origin**—Frederick M. Binkley, M.D., and Jack D. Thorburn, M.D., San Francisco, both by invitation; and H. Brodie Stephens, San Francisco.

Discussion.

10:10—**Mesenteric and Retroperitoneal Apoplexy**—Glenn F. Cushman, M.D., San Francisco.

Discussion.

10:30—**Business Meeting and Election of Officers.**

10:40—**The Diagnosis and Surgical Management of Primary Neoplasms of the Adrenal Gland**—Harry A. Davis, M.D., and Irving A. Fields, M.D., Los Angeles; and Alex Gerber, M.D., Alhambra.

Discussion.

11:10—**Carcinoma of the Colon**—Orville F. Grimes, M.D., and H. Glenn Bell, M.D., San Francisco.

Discussion.

11:20—**The Surgical Treatment of Malignant Melanoma**—Jack M. Farris, M.D., Los Angeles.

Discussion.

11:40—**The Role of Plastic Surgery in Cancer of the Head and Neck**—Edward S. Lamont, M.D., Hollywood.

Discussion.

12:00—**Bilateral Simultaneous Radical Neck Dissection with Recovery—A Report of Two Cases**—S. L. Perzik, M.D., Beverly Hills.

Discussion.

WEDNESDAY, APRIL 30

1:30—Music Room, Biltmore Hotel

Symposium on Cardiac Surgery

For Program, see Section on General Medicine

Admission to Sessions and Exhibits by Registration Badge Only

GENERAL PRACTICE

John B. Long, M.D., Sacramento, *Chairman*
Merlin L. Newkirk, M.D., South Gate, *Secretary*
A. Bradford Carson, M.D., Oakland, *Assistant Secretary*

JOHN B. LONG
Chairman

MERLIN L. NEWKIRK
Secretary

MONDAY, APRIL 28

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Anesthesiology

For Program, see Section on Anesthesiology.

MONDAY, APRIL 28

2:00—Conference Room 2, Biltmore Hotel

2:00—**Management of Common Problems of Abortion**—George E. Judd, M.D., Los Angeles.
Discussion.

2:30—**Early Clinical Diagnoses of Malignant Melanomas**—Molleurus Couperus, M.D., Los Angeles.
Discussion.

3:00—**Treatment of Pain and Neuromuscular Tension with Intravenous Tetracaine (Pontocaine)**—John S. Horan, M.D., Berkeley, by invitation.
Discussion.

3:30—**Indications for Radical Surgery in Extensive Malignant Disease**—Charles J. Miller, M.D., Huntington Park.
Discussion.

4:00—**Impaired Hearing in Children**—H. W. Kohlmoos, M.D., Oakland.
Discussion.

TUESDAY, APRIL 29

9:30—Chapel, Baptist Church, Philharmonic Building

9:30—**The Medical Significance and Treatment of Reading Difficulty**—Roy Swartout, III, M.D., El Monte.
Discussion.

10:00—**Anomalies versus Fractures**—Packard Thurber, Jr., M.D., Los Angeles.
Discussion.

10:30—**Is It a Neurosis?**—John R. Peters, M.D., Los Angeles, by invitation.
Discussion.

11:00—**Chairman's Address: Mental Medication for Your "Sick" Patient**—John B. Long, M.D., Sacramento.

11:30—**Business Meeting—Election of Officers.**

WEDNESDAY, APRIL 30

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Public Health

Symposium on Poliomyelitis

For Program, see Section on Public Health

ALLERGY

Samuel H. Hurwitz, M.D., San Francisco, *Chairman*
M. Coleman Harris, M.D., Vallejo, *Vice-Chairman*
Grace M. Talbott, M.D., San Francisco, *Secretary*

SAMUEL H. HURWITZ
Chairman

GRACE M. TALBOTT
Secretary

WEDNESDAY, APRIL 30

9:30—Conference Room 4, Biltmore Hotel

9:30—The Interpretation of Skin Reactions in California Residents—George F. Harsh, M.D., San Diego.
Discussion.

9:50—Acute Exfoliative Dermatitis Due to Dormison—James Delamater, M.D., Pasadena.
Discussion.

10:10—Pulmonary Infiltration in Allergic Disease—Ben F. Feingold, M.D., San Francisco.
Discussion.

10:30—Anaphylaxis in the Hamster — Lazarre J. Courtright, M.D., and Walter Hook, M.D., San Francisco.
Discussion.

10:50—Observations on Castor Bean Allergy in Southern California—Willard S. Small, M.D., Pasadena.
Discussion.

11:10—Chairman's Address: Allergy as a Specialty —Past Achievements and Future Trends—Samuel H. Hurwitz, M.D., San Francisco.

WEDNESDAY, APRIL 30

2:00—Conference Room 4, Biltmore Hotel

2:00—The Problem of Chronic Urticaria—Robert W. Tufft, M.D., Oakland.
Discussion.

2:30—Bacterial Allergy—Sidney Raffel, M.D., Stanford, by invitation.

3:00—Certain Problems Related to Allergy in Ophthalmology—Rufus C. Goodwin, M.D., San Francisco.
Discussion.

3:25—Recess.

3:45—Psychosomatic and Allergic Study of a Pair of Identical Twins—Robert H. Crede, M.D., San Francisco; Charles Carmen, M.D., San Francisco, by invitation; and Robert Whaley, M.D., and Irwin Schumacher, M.D., San Francisco.
Discussion.

4:10—The Position of Psychotherapy in Allergy: Credits and Debits—Elizabeth Sirmay, M.D., Beverly Hills.
Discussion.

Bring Proper Identification for Registration

ANESTHESIOLOGY

Fenimore E. Davis, M.D., Oakland, *Chairman*
Nevin H. Rupp, M.D., Los Angeles, *Secretary*
Joseph H. Failing, M.D., San Marino, *Assistant Secretary*

FENIMORE E. DAVIS
Chairman

NEVIN H. RUPP
Secretary

MONDAY, APRIL 28

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on General Practice

9:30—**General Anesthetic Agents in General Practice**—Paul Russell, M.D., Inglewood.

Discussion by Willis G. Watrous, M.D., San Jose.

10:00—**Block Anesthesia Suitable for Office Use**—Charles F. McCuskey, M.D., Glendale.

Discussion by Frederick Leix, M.D., Los Angeles.

10:30—**Panel Discussion—Anesthetic Problems in General Practice**

Forrest E. Leffingwell, M.D., Pasadena, Moderator.

Panel: Charles F. McCuskey, M.D.; Paul Russell, M.D.; Frederick Leix, M.D., and Willis G. Watrous, M.D.

MONDAY, APRIL 28

2:00—Conference Room 4, Biltmore Hotel

2:00—**Pathogenesis and Treatment of Causalgia**—Victor Kuenkel, M.D., Los Angeles.

Discussion by Judson Samuel Denson, M.D., Los Angeles.

2:30—**Techniques for Infants' and Children's Anesthesia for the General Practitioner**—Ernest B. Eldridge, M.D., Hollywood.

Discussion by Isabel DeYoung Brown, M.D., Inglewood.

3:00—**Does Your Hospital Need a Recovery Room?**—Thomas McIntosh, M.D., Pasadena.

Discussion by William H. Moran, M.D., La Canada.

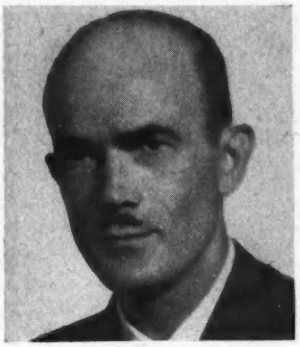
3:30—**Chairman's Address: Experience in Resuscitation of the Newborn**—Fenimore E. Davis, M.D., Oakland.

Discussion by Casimir Harris, M.D., Pasadena, and George W. Bachman, M.D., Altadena.

4:00—**Business Meeting and Election of Officers.**

DERMATOLOGY AND SYPHILOLOGY

J. Walter Wilson, M.D., Los Angeles, *Chairman*
Kenneth L. Stout, M.D., Beverly Hills, *Secretary*
Frances Keddie, M.D., Palo Alto, *Assistant Secretary*



J. WALTER WILSON
Chairman

KENNETH L. STOUT
Secretary

MONDAY, APRIL 28

9:30—Conference Room 2, Biltmore Hotel

9:30—Cytodiagnosis in Virus and Other Diseases of the Skin—Graves Douglas Baldridge, M.D., Los Angeles, by invitation, and Thomas H. Sternberg, M.D., Los Angeles.
Discussion.

9:50—A New Concept in the Treatment of Neurodermatitis—Paul D. Foster, M.D., Los Angeles.
Discussion.

10:10—Chairman's Address: Coccidioidomycosis as a Tool in the Study of Granulomatous Disease—J. Walter Wilson, M.D., Los Angeles.

10:40—Staining Techniques in Ringworm Diagnosis—Robert C. Lofgren, M.D., San Francisco, and Elmer Batts, M.D., San Francisco, by invitation.
Discussion.

11:10—Evidence for Vitamin A Toxicity—Craig Williamson, M.D., Marjorie Bauer, M.D., and Jud R. Scholtz, M.D., Pasadena.
Discussion.

11:30—Cat-Scratch Fever — Ervin Epstein, M.D., Oakland.
Discussion.

11:50—Business Meeting and Election of Officers.

MONDAY, APRIL 28

2:00—Music Room, Biltmore Hotel

Joint Meeting with Section on Pediatrics

Moderator: Arthur H. Parmlee, M.D., Beverly Hills

2:00—Serious and Fatal Skin Diseases in Infants and Children—Edith L. Potter, M.D., Chicago, Illinois, by invitation.
Discussion.

3:00—The Lymphoblastomas in Childhood—Lawrence M. Nelson, M.D., Santa Barbara.
Discussion.

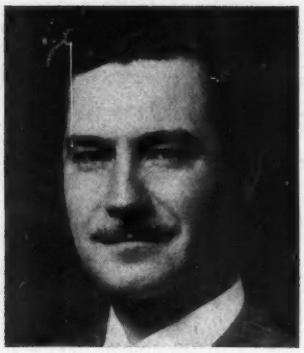
3:20—Moles, Melanomas and Epitheliomas in Childhood—Nelson Paul Anderson, M.D., Los Angeles.
Discussion.

3:40—Skin Diseases of Children in Relation to Lipoid Metabolic Disturbances—Mary B. Olney, M.D., San Francisco.
Discussion.

4:10—Angiomas—Correlation of Clinical with Histological Findings—L. H. Winer, M.D., Beverly Hills.
Discussion.

EYE, EAR, NOSE AND THROAT

Maurice W. Nugent, M.D., Los Angeles, *Chairman*
Robert C. McNaught, M.D., San Francisco, *Secretary*
Alfred R. Robbins, M.D., Los Angeles, *Assistant Secretary*



MAURICE W. NUGENT
Chairman

ROBERT C. McNAUGHT
Secretary

MONDAY, APRIL 28

9:30—Conference Room 8, Biltmore Hotel

9:30—**Theoretical Considerations of the Etiology and Treatment of Epistaxis**—John B. Hollingsworth, M.D., Oakland.
Discussion.

10:00—**Odontogenic Tumors and Cysts**—Walter E. Heck, M.D., San Francisco.
Discussion.

10:30—**Effects of Cortisone on Experimental Lye Burn of the Esophagus**—Alex W. Weisskopf, M.D., San Mateo.
Discussion.

11:00—**Report of a Case of Gunshot Wound of the Trachea**—Wendell Weller, Colonel, MC, USA, San Francisco, by invitation.
Discussion.

11:30—**Extended Laryngectomy with Radical Neck Dissection — One Stage** — S. Kaplan, M.D., Long Beach, by invitation.
Discussion.

MONDAY, APRIL 28

2:00—Conference Room 8, Biltmore Hotel

2:00—**General Anesthetic in Ophthalmology** — George L. Kilgore, M.D., San Diego.
Discussion.

2:30—**Report of a Patient with Stevens-Johnson Syndrome Treated with Cortisone and ACTH** —George P. Landegger, M.D., Los Angeles.
Discussion.

3:00—**A Case of Scleromalacia Perforans**—Orwyn H. Ellis, M.D., Los Angeles.
Discussion.

3:30—**Photophobia**—Jay Randolph Sharpsteen, M.D., Oakland.
Discussion.

4:00—**Intranasal Dacryocystorhinostomy** — Marvin W. Simmons, M.D., Fresno.
Discussion.

4:30—**Business Meeting and Election of Officers.**

Admission to Sessions and Exhibits by Registration Badge Only

INDUSTRIAL MEDICINE AND SURGERY

Herbert C. Sanderson, M.D., Sacramento, *Chairman*
Orris R. Myers, M.D., Eureka, *Secretary*
Packard Thurber, Jr., M.D., Los Angeles, *Assistant Secretary*

HERBERT C. SANDERSON
Chairman

ORRIS R. MYERS
Secretary

MONDAY, APRIL 28

9:30—Conference Room 4, Biltmore Hotel

9:30—**An Unusual Industrial Back**—Harold Crowe, M.D., Los Angeles.
Discussion.

10:00—**Surgery of the Great Toe Joint**—Daniel Levinthal, M.D., Beverly Hills, and George Kraft, M.D., North Hollywood.
Discussion.

10:30—**Exposure Treatment of Burns**—William S. Kiskadden, M.D., and Sanford R. Dietrich, M.D., Los Angeles.
Discussion.

11:00—**The General Practitioner Must Participate in Industrial Health!—How?**—Rutherford T. Johnstone, M.D., Los Angeles.
Discussion.

11:30—**Chairman's Address: Grasping Power**—Herbert C. Sanderson, M.D., Sacramento.

12:00—**Business Meeting and Election of Officers.**

TUESDAY, APRIL 29

9:30—Conference Room 5, Biltmore Hotel

9:30—**Peripheral Vascular Disorders Caused by Industrial Occupations** — Henry Cuneo, M.D., Los Angeles.
Discussion.

10:00—**Special Examination of the Questionable Compensation Claim**—Dan Kilroy, M.D., Sacramento.
Discussion.

10:30—**The Evaluation of Fracture Healing**—Vernon P. Thompson, M.D., Los Angeles.
Discussion.

11:00—**Double Contrast Media Arthrography**—Leon Parker, M.D., San Francisco.
Discussion.

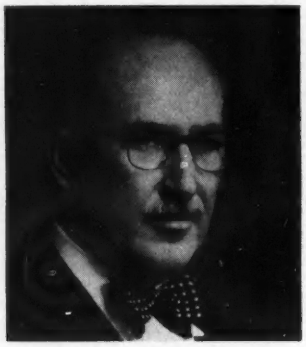
11:30—**Stress of Allergic Backache**—Alonzo J. Neufeld, M.D., Los Angeles.
Discussion.

Bring Proper Identification for Registration

OBSTETRICS AND GYNECOLOGY

Woodburn K. Lamb, M.D., Berkeley, *Chairman*
Hervey K. Graham, M.D., San Diego, *Vice-Chairman*
Donald W. de Carle, M.D., San Francisco, *Secretary*

WOODBURN K. LAMB
Chairman



DONALD W. DE CARLE
Secretary

TUESDAY, APRIL 29

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Urology

For Program, see Section on Urology

WEDNESDAY, APRIL 30

9:30—Chapel, Baptist Church, Philharmonic Building

9:30—**Immediate Postpartum Repair of Third Degree Lacerations**—James V. McNulty, M.D., Los Angeles.
Discussion.

10:00—**The Importance of Proctology in the Field of Obstetrics and Gynecology**—A. J. Murrieta, Jr., M.D., Los Angeles.
Discussion.

10:30—**Retrolental Fibroplasia: Blindness in Infants of Low Birth Weight** — Alfred Appelbaum, M.D., Huntington Park.
Discussion.

11:00—**Studies of Blood Volume During Pregnancy** —Carl Goetsch, M.D., Berkeley.
Discussion.

11:30—**Business Meeting and Election of Officers.**

WEDNESDAY, APRIL 30

2:00—Auditorium, Sunkist Building

2:00—**Chairman's Address**—Woodburn K. Lamb, M.D., Berkeley.

2:30—**Lesions of the Cervix**—Wilson Footer, M.D., Oakland.
Discussion.

3:00—**The Acute Abdomen in Pregnancy**—Charles Langmade, M.D., Pasadena.
Discussion.

4:00—**Sexual Functions of the Pubococcygeus Muscle—Diagnosis and Therapy**—Arnold H. Kegel, M.D., Los Angeles.
Discussion.

Visit the Technical and Scientific Exhibits

PATHOLOGY AND BACTERIOLOGY

Leon John Tragerman, M.D., Los Angeles, *Chairman*
Charles M. Blumenfeld, M.D., Sacramento, *Secretary*
A. R. Camero, M.D., Los Angeles, *Assistant Secretary*

LEON JOHN TRAGERMAN
Chairman

CHARLES M. BLUMENFELD
Secretary

MONDAY, APRIL 28

9:30—Conference Room 5, Biltmore Hotel

9:30—**The Alperene Granuloma After Injection Therapy in Hernia**—Leo Kaplan, M.D., Los Angeles, by invitation.

9:50—**Modifications of the Middlebrook-Dubos Test**—Bruno Gerstl, M.D., Oakland; and J. W. Winter, Ph.D., and A. G. Hollander, M.D., Oakland, both by invitation.

10:10—**Cytomegalic Inclusion Disease in an Adult**—J. D. Langston, Commander (MC) USN, and J. L. Zundell, Capt. (MC) USN, Oakland, by invitation.

10:30—**A Classification of Parotid Tumors**—G. Gordon Hadley, M.D., and Louisa Keasbey, M.D., Los Angeles.

11:00—**The Mechanical Effects of the Displacement of the Brain by Tumor**—J. W. Kernohan, M.D., Rochester, Minn., by invitation.

MONDAY, APRIL 28

2:00—Conference Room 5, Biltmore Hotel

2:00—**Coccidioidomycosis of the Epididymis—Report of Two Cases**—George Amromin, M.D., Exeter, and Charles M. Blumenfeld, M.D., Sacramento.

2:20—**Chairman's Address**—Leon John Tragerman, M.D., Los Angeles.

3:00—**Papillomas of the Breast**—Jesse Carr, M.D., San Francisco, and Milton Rosenthal, M.D., Los Angeles.

3:20—**Carcinoma of the Prostate in Males Eighty or Over**—Albert E. Hirst, Jr., M.D., and R. T. Bergman, M.D., Los Angeles.

3:40—**Business Meeting—Election of Officers.**

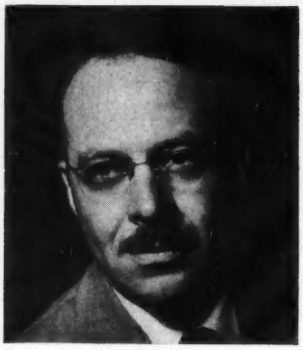
4:10—**Recess—Semi-annual Meeting, California Society of Pathologists.**

Admission to Sessions and Exhibits by Registration Badge Only

PEDIATRICS

Joseph W. St. Geme, M.D., Los Angeles, *Chairman*
Alvin H. Jacobs, M.D., San Francisco, *Secretary*
Clement J. Molony, M.D., Beverly Hills, *Assistant Secretary*

JOSEPH W. ST. GEME
Chairman



ALVIN H. JACOBS
Secretary

MONDAY, APRIL 28

9:30—Auditorium, Southern California Edison Building

9:30—**Anuria Due to Urethral Obstruction by a Sulfonamide Derivative**—Carl L. Biorn, M.D., Palo Alto.

10:00—**Breath-Holding Spells** — Lloyd B. Dickey, M.D., San Francisco.

10:30—**Bronchoscopy of the Newborn** — Robin P. Michelson, M.D., San Francisco.
Discussion by Simon Jesberg, M.D., Los Angeles.

11:00—**Emergencies in the Newborn**—Gilbert M. Jorgensen, M.D., Los Angeles.
Discussion by Mr. V. Ray Bennett, by invitation, Los Angeles.

11:30—**Evaluation of ACTH and Cortisone Therapy in Rheumatoid Arthritis**—Merl J. Carson, M.D., by invitation, and Mary Mulloy, M.D., by invitation, Los Angeles.

12:00—**Business Meeting.**

MONDAY, APRIL 28

2:00—Music Room, Biltmore Hotel

Joint Meeting with Section on Dermatology and Syphilology

For Program, see Section on Dermatology and Syphilology

WEDNESDAY, APRIL 30

2:00—Auditorium, Southern California Edison Building

Panel Discussion

What's New in Pediatrics

2:00—**Recent Advances in Pediatric Surgery**—Victor Richards, M.D., San Francisco.

2:20—**Treatment of the Nephrotic Syndrome** — Edward C. Persike, M.D., San Francisco.

2:40—**Common Household Poisoning**—Rea F. Chittenden, M.D., North Hollywood.

3:00—**The Adoption Problem**—Donald G. Tollefson, M.D., Los Angeles.

3:20—**The Feeding of Premature Infants with the Indwelling Polyethylene Catheter** — Stephen Royce, M.D., San Marino.

3:40—**The Treatment of Burns in Children**—Allyn J. McDowell, M.D., North Hollywood.

4:00—**The Challenge of the Well Child** — A. Joe Scull, M.D., San Francisco, by invitation.

4:20—**Open Discussion:** Questions from the floor are invited.

PSYCHIATRY AND NEUROLOGY

O. W. Jones, Jr., M.D., San Francisco, *Chairman*
Cyril B. Courville, M.D., Los Angeles, *Secretary*
Aidan A. Raney, M.D., Los Angeles, *Assistant Secretary*

O. W. JONES, JR.
Chairman

CYRIL B. COURVILLE
Secretary

WEDNESDAY, APRIL 30

9:30—Conference Room 8, Biltmore Hotel

9:30—**Chairman's Address: Traumatic Chronic Subdural Hematoma**—O. W. Jones, Jr., M.D., San Francisco.

10:00—**New Vistas in Psychosomatic Medicine**—Alfred E. Coodley, M.D., Los Angeles.

Discussion by Philip Solomon, M.D., Beverly Hills, and Julius Bauer, M.D., Hollywood.

10:30—**Studies in Cerebral Metabolism**—Eugene Eisenberg, M.D., John E. Adams, M.D., Gilbert Gordon, M.D., San Francisco; and Richard Bentinck, M.D., and Harold Harper, Ph.D., San Francisco, both by invitation.

Discussion by Augustus Rose, M.D., and Horace W. Magoun, Ph.D., Los Angeles.

11:00—**The Problem of Barbiturate Intoxication—Recent Advances in Its Therapeutic Management**—Eugene A. Hargrove, M.D.; A. E. Bennett, M.D.; and F. R. Ford, M.D., Berkeley.

Discussion by Esther Bogen Tietz, M.D., Los Angeles.

11:30—**Auxiliary Treatment of Psychotic Women—Group Therapy with Their Husbands**—Gene Gordon, M.D., by invitation, and Karl M. Bowman, M.D., San Francisco.

Discussion by Esther Somerfeld-Ziskind, M.D., Los Angeles, and Samuel Futterman, M.D., Beverly Hills.

WEDNESDAY, APRIL 30

2:00—Conference Room 8, Biltmore Hotel

2:00—**Business Meeting and Election of Officers.**

2:10—**Postural Vertigo and Positional Nystagmus**—Russell Fletcher, M.D., San Rafael.

Discussion.

2:40—**Prognosis of Language Disabilities**—J. Ray Van Meter, M.D., San Francisco, and Ruth W. Van Meter, M.A., San Francisco, by invitation.

Discussion by J. M. Nielsen, M.D., Los Angeles.

3:10—**Hyperinsulinism (Pancreatic Adenoma) Associated with Neuromuscular Disorders**—Ralph W. Barris, M.D., La Jolla.

Discussion.

3:40—**Unilateral Deafness from Pontine Lesion**—J. M. Nielsen, M.D., Los Angeles; and J. Sloan Berryman, M.D., Beverly Hills, by invitation.

Discussion.

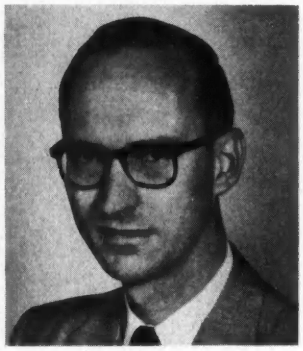
4:10—**The Surgical Treatment of Infantile Hydrocephalus**—Tracy J. Putnam, M.D., Beverly Hills.

Discussion by Carl W. Rand, M.D., and Frank M. Anderson, M.D., Los Angeles.

PUBLIC HEALTH

J. B. Askew, M.D., San Diego, *Chairman*
John R. Philp, M.D., Chico, *Secretary*
Charles E. Smith, M.D., Berkeley, *Assistant Secretary*

J. B. ASKEW
Chairman



JOHN R. PHILP
Secretary

TUESDAY, APRIL 29

2:00—Conference Room 2, Biltmore Hotel

2:00—Congenital Syphilis in California—A. Frank Brewer, M.D., and Philip Condit, M.D., Berkeley.
Discussion.

2:30—The Preventable Diseases—The Scope of Public Health—Haven Emerson, M.D., New York, N. Y., by invitation.
Discussion.

3:00—Recess.

3:15—Diabetes Detection Combined with a Chest X-Ray Survey—B. K. Milmore, M.D., Berkeley, by invitation; Howard B. Flanders, M.D., Walnut Creek, and Henrik L. Blum, M.D., Martinez.
Discussion.

3:45—Bronchogenic Carcinoma in San Diego County—Ambrose S. Churchill, M.D., San Diego.
Discussion.

4:15—Chairman's Address—J. B. Askew, M.D., San Diego.

4:35—Business Meeting—Election of Officers.

WEDNESDAY, APRIL 30

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on General Practice

Symposium

Poliomyelitis

9:30—The Relationship Between Immunizing Injections and Paralytic Poliomyelitis — Robert Drake, M.D., Berkeley, by invitation.

9:50—Possible Home Treatment of Poliomyelitis—Martin Mills, M.D., Richmond.

10:10—The Role of the Small Hospital in the Treatment of Poliomyelitis — Edward B. Shaw, M.D., and H. E. Thelander, M.D., San Francisco.

10:30—Recess.

10:50—Tonsillectomy and Ear, Nose and Throat Surgery and Their Effect on the Incidence of Poliomyelitis — Alden H. Miller, M.D., Los Angeles.

11:10—Panel Discussion: Questions from the Floor.
Panel Discussants: Robert Drake, M.D., Martin Mills, M.D., Edward B. Shaw, M.D., and Alden H. Miller, M.D.

Admission to Sessions and Exhibits by Registration Badge Only

RADIOLOGY

Harold P. Tompkins, M.D., Los Angeles, *Chairman*
Robert K. Arbuckle, M.D., Oakland, *Secretary*
Calvin L. Stewart, M.D., San Diego, *Assistant Secretary*

HAROLD P. TOMPKINS
Chairman

ROBERT K. ARBUCKLE
Secretary

MONDAY, APRIL 28

9:30—Auditorium, Sunkist Building

Joint Meeting with Sections on General Surgery and General Medicine

For Program, see Section on General Medicine.

TUESDAY, APRIL 29

9:30—Conference Room 9, Biltmore Hotel

9:30—**Lesions Simulating Carcinoma of the Colon**—H. R. Morris, M.D., Redlands.

9:50—**The Value of Delayed Films in Bronchography**—Herbert L. Abrams, M.D., and Gerhard R. Hencky, M.D., San Francisco.

10:10—**Roentgen Diagnosis of Retroperitoneal Tumors in Children**—Howard L. Steinbach, M.D., and Reynold F. Brown, M.D., San Francisco.

10:30—**Review of 1,000 Cases of Enlarged Thymus Treated by Irradiation**—John D. Lawson, M.D., and E. Revere Cole, M.D., Sacramento.

10:50—**Recess—Business Meeting.**

11:00—**Annual Meeting of Pacific Roentgen Society.**

WEDNESDAY, APRIL 30

9:30—Room 9, Biltmore Hotel

9:30—**Ameloblastoma**—Frank C. Binkley, M.D., Pasadena.

9:50—**Irradiation Therapy of Vascular Nevi**—Roy W. Johnson, M.D., Los Angeles.

10:10—**Hemangioma: To Treat or Not to Treat**—Sydney F. Thomas, M.D., and Esther B. Clark, M.D., Palo Alto.

10:30—**Radiation Therapy of Eye Diseases**—Robert Stanton Sherman, Jr., M.D., San Francisco.

10:50—**Recess.**

11:00—**The Metabolic Behavior of Astatine and Its Destructive Effect Upon the Thyroid in Experimental Animals**—Joseph G. Hamilton, M.D., Berkeley, by invitation.

11:20—**Chairman's Address—Primary Carcinoma of the Duodenum**—Harold P. Tompkins, M.D., Los Angeles.

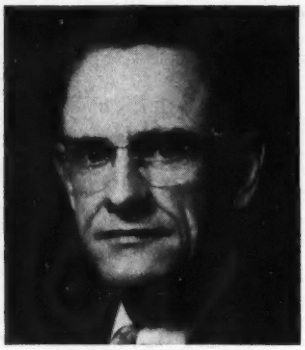
11:40—**Roentgen Diagnosis of Meningiomas**—Eugene P. Pendergrass, M.D., Philadelphia, Pennsylvania, by invitation.

Bring Proper Identification for Registration

UROLOGY

Donald R. Smith, M.D., San Francisco, *Chairman*
Roger W. Barnes, M.D., Los Angeles, *Secretary*
James A. May, M.D., San Diego, *Assistant Secretary*

DONALD R. SMITH
Chairman



ROGER W. BARNES
Secretary

TUESDAY, APRIL 29

9:30—Music Room, Biltmore Hotel

Joint Meeting with Section on Obstetrics and Gynecology

9:30—The Urinary Tract in Carcinoma of the Female Genitalia — Charles A. Gallup, M.D., Pasadena.

Discussion opened by Ralph J. Thompson, M.D., Los Angeles.

10:00—What's New in Infertility—Murray Russell, M.D., Beverly Hills, and Emil J. Krahulik, M.D., Los Angeles.

Discussion opened by Lewis Michelson, M.D., San Francisco.

10:30—Etiologic Factors in Female Stress Incontinence—J. G. Moore, M.D., Los Angeles.

Discussion opened by Henry M. Weyrauch, M.D., San Francisco.

11:00—Urethral Diverticula in the Female—R. Theodore Bergman, M.D., Los Angeles.

Discussion opened by Harry A. Zide, M.D., Beverly Hills.

11:30—The Use and Abuse of Antibiotics in Gynecological and Urological Diseases—Arnold F. Settlage, M.D., Los Angeles; and Stanley H. Moulton, M.D., Los Angeles, by invitation.

Discussion opened by A. M. McCausland, M.D., Los Angeles.

WEDNESDAY, APRIL 30

9:30—Conference Room 5, Biltmore Hotel

9:30—Recurrent Urinary Tract Infection from Urethral Stenosis in Young Girls—John W. Schulte, M.D., San Francisco, and Gordon Williams, M.D., Menlo Park.

10:00—The Retropubic Approach to Vesical Neck Obstruction in Children—Bradford W. Young, M.D., San Francisco.

Discussion of papers by Drs. Schulte and Young to be opened by Samuel K. Bacon, M.D., Hollywood.

10:30—The Chronically Congested Prostate—Stanley E. Farley, M.D., Riverside.

Discussion opened by Carl F. Rusche, M.D., Hollywood.

11:00—Mullerian Duct Remnants—Vincent Moore, M.D., San Diego, by invitation, and Robert J. Prentiss, M.D., San Diego.

Discussion opened by Earl F. Nation, M.D., Pasadena.

11:30—The Diagnosis and Treatment of Carcinoma of the Prostate—Joseph C. Presti, M.D., San Francisco.

Discussion opened by Willard Goodwin, M.D., Los Angeles.

WEDNESDAY, APRIL 30

2:00—Conference Room 5, Biltmore Hotel

2:00—Chairman's Address: The Treatment of Hypospadias—Donald R. Smith, M.D., San Francisco.

2:30—**Urography as a Test of Urinary Tract Function**—Eugene P. Pendergrass, M.D., Philadelphia, Pennsylvania, by invitation.

Discussion opened by Elmer Belt, M.D., Los Angeles.

3:00—**The Management of the Patient with Ureteral Calculi**—Ector Le Duc, M.D., San Diego.

Discussion opened by Milo Ellik, M.D., Long Beach.

3:30—**Transvesical Repair of Complicated Vesicovaginal Fistulae** — Franklin Farman, M.D., Whittier; Leslie Kamens, M.D., and James Holloway, M.D., both by invitation, Whittier.

Discussion opened by Edward W. Beach, M.D., Sacramento.

4:00—**Business Meeting and Election of Officers.**

ANNUAL GOLF TOURNAMENT

The Annual Golf Tournament will be held at the Wilshire Country Club, Tuesday afternoon, April 29. All members attending the meeting are welcome to play. Numerous prizes will be awarded. No reservations are necessary. The Golf Club would like members to tee off by twelve o'clock. For information contact W. L. Roberts, M.D., Secretary, Southern California Medical Golf Association, 727 West Seventh Street, Los Angeles; telephone TUcker 2417.

EMERGENCY CALLS

Notify your office or exchange regarding the meetings you plan to attend. In cases of emergency, when the doctor cannot be located, the call will be referred to Emergency Call Service of the Los Angeles County Medical Association, DUnkirk 7-7175; Sunday and evenings after 5:00 p.m., DUnkirk 7-8141.

Motion Picture Program

ARTHUR E. SMITH, M.D., D.D.S., Los Angeles, *Chairman*

Medical Motion Pictures Committee

SURGICAL FILM EXHIBITION

SUNDAY, APRIL 27

1:00 to 5:26 p.m., Biltmore Hotel, Conference Room 1

1:00—**Examination of the Breast for Early Cancer**—State of California Department of Public Health; Cancer Commission, California Medical Association.

1:15—**Thymectomy for Myasthenia Gravis**—W. H. Snyder, Jr., M.D., and S. Austin Jones, M.D., Los Angeles.

1:25—**Curare, Intocostrin, d-Tubocurarine Chloride, Mecostrin**—John B. Dillon, M.D., San Gabriel (A Squibb medical film).

1:50—**Pneumonectomy for Bronchogenic Carcinoma**—Lyman A. Brewer, M.D., and Frank Dolley, M.D., Los Angeles.

2:10—**Cholecystojejunostomy**—Philip Thorek, M.D., Chicago.

2:25—**Pulmonary Valvulotomy** — John C. Jones, M.D., Los Angeles.

2:40—**Right Colon Resection with End-to-End Anastomosis**—Howard H. Drake, M.D., Los Angeles.

2:55—**Thoracic Repair of Diaphragmatic Hernia**—Conrad J. Baumgartner, M.D., Beverly Hills.

3:20—**Radical Neck Dissection**—Frank H. Lahey, M.D., Boston.

3:38—**Repair of a Postoperative Ventral Hernia**—Kenneth C. Sawyer, M.D., and J. Robert Spencer, M.D., Denver.

3:59—**Resection of Right Colon**—Arthur W. Allen, M.D., Boston.

4:14—**Technic of Vaginal Hysterectomy**—Virgil S. Counsellor, M.D., Rochester, Minnesota.

4:41—**Bilateral Femoral Vein Interruption**—Robert R. Linton, M.D., Boston.

5:08—**Subdermal Hematoma**—J. Rudolph Jaeger, M.D., Philadelphia.

MONDAY, APRIL 28

9:00 a.m. to 5:33 p.m., Biltmore Hotel, Conference Room 1

9:00—**Repair of Ruptured Membranous Hernia**—United States Army.

9:08—**Temporomandibular Joint Dysfunction** — S. Daniel Seldin, M.D., D.D.S., New York City.

9:28—**Abdomino-Perineal Resection of Rectum** — Francis C. Newton, M.D., and J. Engelbert Dunphy, M.D., Boston.

10:00—**Surgical Anatomy of the Female Perineum (Cadaver Surgery)**—R. Theodore Bergman, M.D., Roger W. Barnes, M.D., Los Angeles; Elton L. Morel, M.D., Glendale.

10:30—**Antabuse in the Treatment of Alcoholism**—A. E. Bennett, M.D., and Eugene A. Hargrove, M.D., Berkeley.

10:47—**Precancer Diagnosis of the Cervix by Cytology**—J. Ernest Ayre, M.D., Montreal, Canada.

11:12—**Removal of Magnetic Foreign Bodies from the Eye**—United States Army.

11:26—**Polyps of the Large Intestines**—Hilger Perry Jenkins, M.D., and Associates, Chicago.

11:51—**Hypertension Due To Pheochromocytoma** — Reginald H. Smithwick, M.D., Boston.

12:06—**Use of Artificial Kidney**—John P. Merrill, M.D., Boston.

12:21—**Tic Douloureux — Its Diagnosis and Treatment**—J. Rudolph Jaeger, M.D., Philadelphia.

12:54—**Low Spinal (Modified Saddle-Block) Anesthesia in Obstetrics**—William J. Dieckman, M.D., M. Edward Davis, M.D., and George J. Andros, M.D., Chicago (A Ciba medical film).

1:12—**The Physiologic Basis for the Action of ACTH in Human Beings**—Armour Laboratories, Chicago.

1:57—**Total Abdominal Hysterectomy; Bilateral Salpingo-Oophorectomy** — Douglas Donath, M.D., Pasadena.

2:12—**Surgical Approaches to the Knee Joint** — LeRoy C. Abbott, M.D., San Francisco.

2:52—**Diabetic Gangrene**—Walter Scott, M.D., Hollywood.

3:12—**Amputations for Trauma** — Paul F. Olson, M.D., North Hollywood.

3:22—**Surgical Preparation of the Mouth for Immediate Dentures** — Ralston I. Lewis, M.D., D.D.S., Chicago.

3:38—**The Anesthesiologist Positions the Patient**—Nevin H. Rupp, M.D., and Robert M. Campbell, M.D., Veterans Hospital, Los Angeles.

3:53—**Reconstructive Plastic Surgery of the Nose**—Arthur E. Smith, M.D., D.D.S., Los Angeles.

4:23—**Watkins-Wertheim Interposition Operation**—Bernard J. Hanley, M.D., Dept. of Obstetrics and Gynecology, University of Southern California, Los Angeles.

4:35—**Studies of the Coronary Circulation**—Myron Prinzmetal, M.D., Eliot Corday, M.D., H. C. Bergman, Ph.D., Lois L. Schwartz, M.D., and Ramon J. Spritzler, M.D., Beverly Hills.

5:05—**Thyroidectomy for Papillary Carcinoma of Thyroid**—George Crile, Jr., Cleveland.

5:23—**Operation for Varicocele** — United States Army.

TUESDAY, APRIL 29

9:00 a.m. to 5:21 p.m., Biltmore Hotel, Conference Room 1

9:00—**Transduodenal Exploration of Common Duct and Sphincter of Oddi**—Philip Thorek, M.D., Chicago.

9:14—**Abdominal Fascial Transplants** — Charles L. Lowman, M.D., Los Angeles.

9:44—**Transplantation of Ureters into Rectosigmoid and Cystectomy for Carcinoma of Bladder**—Charles C. Higgins, M.D., Cleveland.

10:10—**Parotidectomy**—Robert A. Wise, M.D., Portland, Oregon.

10:36—**Inguinal Hernia Repair** — John C. Rooney, M.D., Santa Monica.

10:48—**Patellectomy**—Paul E. McMaster, M.D., Beverly Hills.

11:08—**Transthoracic Repair of Traumatic Diaphragmatic Hernia**—H. E. Schiffbauer, M.D., Los Angeles.

11:23—**Trigeminal Neuralgia** — Rupert B. Raney, M.D., Los Angeles.

11:35—**Supraomohyoid Neck Dissection for Removal of Cervical Lymph Node Metastases Following Operation for Carcinoma of the Lip**—Grantley W. Taylor, M.D., Boston.

11:48—**Abdomino-Perineal Resection for Carcinoma of the Rectum**—Richard B. Cattell, M.D., Boston.

12:07—**Congenital Absence of Vagina** — Virgil S. Counsellor, M.D., Rochester, Minnesota.

12:24—**The Surgical Preparation of the Mouth for Dentures**—V. H. Kazanjian, M.D., D.D.S., Boston.

12:39—**Anomalies of the Bile Duct-Blood Vessels and Strictures of the Common Duct**—Warren H. Cole, M.D., Chicago (Produced for Motion Picture Program), American College of Surgeons.

12:55—**Sympathetic Nerve Block** — United States Army.

1:10—**Splenorenal Anastomosis for Portal Hypertension**—C. Stuart Welch, M.D., Boston.

1:29—**Total Hysterectomy**—William H. Brownfield, M.D., Los Angeles.

1:44—**Osteochondromatosis of Joints and Bursae**—Hugh Toland Jones, M.D., Los Angeles.

1:59—**Diverticulum of the Female Urethra**—Charles M. Stewart, M.D., Los Angeles.

2:17—**Thoracolumbar Sympathectomy**—J. Norman O'Neill, M.D., Los Angeles.

2:34—**Pulsion Diverticulum of the Hypopharynx (Esophagus)** — Harold Lincoln Thompson, M.D., Los Angeles.

2:49—**Utero-Sigmoidostomy** — Carl Rusche, M.D., Los Angeles.

3:04—**Peritoneoscopy**—R. Nichol Smith, M.D., Los Angeles.

3:18—**A New Surgical Approach for the Correction of Congenital Retrusion of the Mandible: Congenital Undeveloped Symphysis; Acquired Deformity of Palate with Marked Protrusion of the Upper Alveolar Arch and Teeth** — Marsh Robinson, D.D.S., M.D., Los Angeles.

3:43—**Total Hysterectomy Technique and Safeguards**—John M. Fernald, M.D., Los Angeles.

3:58—**Removal of Submaxillary Gland for Chronic Inflammation**—E. Eric Larson, M.D., Los Angeles.

4:13—**Surgical Management of Chiasmal Lesions Producing Progressive Loss of Vision** — C. Hunter Shelden, M.D., Pasadena.

4:33—**Pseudopancreatic Cyst**—Finis G. Cooper, M.D., Huntington Park.

5:03—**The Dynamics of Phakoerysis**—David O. Harrington, M.D., San Francisco.

TUESDAY EVENING, APRIL 29

7:00 p.m. to 10:55 p.m., Biltmore Hotel, Conference Room 1

7:00—**Myomectomy and Myometrial Reconstruction**—A. R. Abarbanel, M.D., Los Angeles.

7:30—**Demonstrating a New Technique for the Repair of the Fibular Collateral Ligament**—John R. Black, M.D., Los Angeles.

7:50—**Surgical Approach to the Kidney Through the Superior Lumbar Triangle** — Elmer Belt, M.D., Los Angeles.

8:20—**The Importance of Early Adequate Surgery in Carcinoma of the Breast: Results in a Case of Late Radical Surgical and Hormone Management**—Louis C. Bennett, M.D., Los Angeles.

8:37—**Plastic Surgical Reconstruction of Tissues Lost From Physical Injuries. Extensive Skin Grafting and Treatment**—Arthur E. Smith, M.D., D.D.S., Los Angeles.

9:10—**Excision of Thyroglossal Cyst** — Conrad J. Baumgartner, M.D., Beverly Hills.

9:32—**Recurrent Dislocation of the Shoulder, a Modification of the Magnuson Procedure**—William Molony, Jr., M.D., Los Angeles.

9:46—**Radical Groin Dissection for Malignant Melanoma**—Jack M. Farris, M.D., Los Angeles.

10:03—**Correction of Congenital Ear Canal Atresia with Replacement of Hearing**—Howard P. House, M.D., Los Angeles.

10:28—**Gelfoam in Surgery**—United States Army.

WEDNESDAY, APRIL 30

9:00 a.m. to 4:57 p.m., Biltmore Hotel, Conference Room 1

9:00—**Keratoplasty**—Ramon Castroviejo, M.D., New York City.

9:17—**Transthoracic Partial Gastrectomy with Intrathoracic Esophago-Gastric Anastomosis for Carcinoma of the Cardia**—Richard H. Sweet, M.D., Boston.

9:45—**First Aid Treatment of Fractures of Lower Extremity**—Kellogg Speed, M.D., Chicago.

9:57—**Cerebral Hemispherectomy**—Herbert G. Crockett, M.D., Los Angeles.

10:22—**Replacement Arthroplasty with Judet Prosthesis Using the Gibson Approach**—Stanley S. Haft, M.D., Los Angeles.

10:34—**Implantation for Enucleation** — Clarence H. Albaugh, M.D., Los Angeles.

10:54—**Procto-Sigmoidoscopic Findings**—David Miller, M.D., Los Angeles.

11:07—**One-Stage Mammaryplasty with Free Transplantation of the Nipples** — William Milton Adams, M.D., Memphis.

11:27—**Excision Anal Fissure, Fistulectomy and Hemorrhoidectomy with Caudal Anesthesia**—Neil Swinton, M.D., and Urban Eversole, M.D., Boston.

11:58—**Surgical Correction of Prognathism**—George F. Seeman, D.D.S., Nashville.

12:14—**Correction of Protruding Ears** — Oscar J. Becker, M.D., Chicago.

12:30—**Reduction of Zygomatic Fracture**—Victor H. Frank, D.D.S., Philadelphia.

12:40—**Pentothal in Oral Surgery**—W. C. Guralnick, M.D., D.M.D., Boston.

1:00—**Treatment of Varicose Veins** — Thomas A. Shallow, M.D., Philadelphia.

1:18—**Wardill Type of Push-Back Operation for Cleft Palate**—Gordon B. New, M.D., Rochester, Minnesota.

1:31—**Surgery for Hypersplenism**—Robert M. Zollinger, M.D., Columbus, Ohio.

1:53—**Moles and Melanoma of the Skin** — United States Navy.

2:07—**Plastic Surgical Reconstruction of Cleft Lip** —James F. Dowd, M.D., St. Louis.

2:21—**Surgical Management of Primary Hyperthyroidism**—Frank H. Lahey, M.D., Boston.

2:43—**Removal of a Mandibular Radicular Cyst** — Leonard Z. Lyon, D.D.S., Los Angeles.

3:03—**Thoracolumbar Sympathectomy for Hypertension**—James L. Poppen, M.D., Boston.

3:33—**Management of Abdominal Colostomies** — United States Army.

3:57—**Correction of Facial Paralysis by Muscle Substitution** — William Milton Adams, M.D., Memphis.

4:15—**Surgical Correction of Nasopharyngeal Atresia, Complete**—Arthur Dick, D.D.S., M.D., Washington.

4:27—**Cardiac Arrhythmias**—Department of Physiology, University of Chicago.

Scientific Exhibits

Renaissance Room and Galeria, Biltmore Hotel

• *Renaissance Room*

Plastic Embedding of Medical Teaching Material—Joseph A. Weinberg, M.D.; and James L. Kerns, Long Beach, by invitation; and Charles F. Bridgman, Los Angeles, by invitation.

Double Contrast Media Arthrography—Leon O. Parker, M.D., and Alfred A. de Lorimier, M.D., San Francisco.

Pulmonary Tuberculosis—Fundamentals of Therapy —E. W. Hayes, M.D., Monrovia; A. A. Adames, M.D., Holtville; L. S. Jacobs, M.D., Monrovia; E. W. Hayes, Jr., M.D., Long Beach, by invitation; and Vernon Rickard, M.D., Holtville.

The Diagnosis of Malignant Melanoma—Molleurus Couperus, M.D., and Rufus C. Rucker, M.D., Los Angeles.

Transvesical Repair of Complicated Vesico-Vaginal Fistula—Franklin Farman, M.D., Whittier; Leslie Kamens, M.D., and James W. Holloway, M.D., Whittier, both by invitation.

• *Renaissance Room*

Thyroxine Synthesis—A Clinical Measure of Thyroid Function—M. E. Morton, M.D., Los Angeles, by invitation.

Correlative Study of Cardiac Diseases—Irving Treiger, M.D., Beverly Hills.

Treatment of Peripheral Arterial Insufficiency—Albert Fields, M.D., and W. A. Selle, Ph.D., by invitation, Los Angeles.

• *Galeria*

Tests for Intoxication — Joseph B. Davis, M.D., Oceanside.

Psychiatric Art Therapy—Brunon Bielinski, M.D., Los Angeles, and Oletha Paul Fowler, by invitation, Los Angeles.

Plastic Surgery Problems in Children—Kathryn L. Stephenson, M.D., Santa Barbara.

Diagnosis of Complete Transposition of Great Vessels —Herbert L. Abrams, M.D., San Francisco.

Plastic Gastrointestinal Tubes in Diagnosis, Treatment and Postoperative Management—Arthur L. Kaslow, M.D., and William F. Quinn, M.D., Los Angeles.

Organizational Exhibits

Galeria, Biltmore Hotel

C.M.A. Postgraduate Activities Committee

C.M.A. Blood Bank Commission

American Cancer Society

U. S. Food and Drug Administration

American Physical Therapy Association, Northern California Chapter

C. M. A. Cancer Commission Pre-Convention Conference

LOS ANGELES—SATURDAY, APRIL 26

The pre-convention conferences sponsored by the Cancer Commission will be held on Saturday, April 26, the day preceding the opening of the California Medical Association meeting, at the Biltmore Hotel and in the Auditorium of the Los Angeles County Medical Association.

Pathology

Auditorium, Los Angeles County Medical Association Building, 1925 Wilshire Boulevard

The pre-convention Conference on Microscopic Tumor Pathology will be held from 9:30 a.m. to 12 noon and from 2 to 4 p.m. under the chairmanship of Dr. James E. Kahler, Los Angeles. Dr. James W. Kernohan, head of the Section on Pathologic Anatomy and Neuropathology, Mayo Clinic, Rochester, Minnesota, will be the moderator. Tumor diagnostic problems will be presented and discussed with emphasis on tumors of the central nervous system. Members who attend this conference are requested to register now with Dr. E. M. Hall, Tumor Tissue Registry, C.M.A. Cancer Commission, Los Angeles County General Hospital, 1200 No. State Street, Los Angeles 33.

Radiology

Conference Room 1, Biltmore Hotel

The pre-convention Conference on Radiology will be held from 9:30 a.m. to 12 noon and from 2 p.m. to 4:30 p.m. under the chairmanship of Dr. Merrell A. Sisson of San Francisco. Dr. J. F. Linsman of Beverly Hills is Secretary.

INDEX TO SPEAKERS

Los Angeles, April 27-30, 1952

SCIENTIFIC SESSIONS

	SUNDAY APRIL 27		MONDAY APRIL 28		TUESDAY APRIL 29		WEDNESDAY APRIL 30	
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.
BILTMORE THEATRE		**3:00** General Meeting		**2:00** General Meeting and Clinical-Pathological Conference				
BILTMORE HOTEL Music Room	**9:30 House of Delegates**		**9:30** General Practice Anesthesiology	**2:00** Dermatology and Syphilology Pediatrics	**9:30** Obstetrics and Gynecology Urology	**1:30 House of Delegates**	**9:30** Public Health General Practice	**1:30** General Medicine General Surgery Calif. Heart Assn.
Conference Room 2			**9:30** Dermatology and Syphilology	**2:00** General Practice		**2:00** Public Health		
Conference Room 4			**9:30** Industrial Medicine and Surgery	**2:00** Anesthesiology			**9:30** Allergy	**2:00** Allergy
Conference Room 5			**9:30** Pathology and Bacteriology	**2:00** Pathology and Bacteriology	**9:30** Industrial Medicine and Surgery		**9:30** Urology	**2:00** Urology
Conference Room 8			**9:30** Eye, Ear, Nose and Throat	**2:00** Eye, Ear, Nose and Throat			**9:30** Psychiatry and Neurology	**2:00** Psychiatry and Neurology
Conference Room 9					**9:30** Radiology		**9:30** Radiology	
BAPTIST CHURCH Chapel Fifth and Olive Sts.					**9:30** General Practice		**9:30** Obstetrics and Gynecology	
SO. CALIFORNIA EDISON BLDG. Fifth and Grand Sts.			**9:30** Pediatrics		**9:30** General Surgery		**9:30** General Surgery	**2:00** Pediatrics
SUNKIST BUILDING Fifth and Flower Sts.			**9:30** General Medicine General Surgery Radiology		**9:30** General Medicine		**9:30** General Medicine	**2:00** Obstetrics and Gynecology
BILTMORE HOTEL Conference Room 1		**1:00-5:30 p.m.** **Medical Motion Pictures**	**9:00 a.m. to 5:30 p.m.** **Medical Motion Pictures**		**9:00 a.m. to 5:30 p.m.** **Medical Motion Pictures** **7:00 p.m. to 11:30 p.m.**		**9:00 a.m. to 4:30 p.m.** **Medical Motion Pictures**	

COUNCIL OF THE C.M.A. MEETS DAILY AT 7:30 A.M. IN CONFERENCE ROOM 6, BILTMORE HOTEL

SCIENTIFIC EXHIBITS—RENAISSANCE ROOM AND GALERIA, BILTMORE HOTEL

HOUSE OF DELEGATES MEETS SUNDAY, 9:30 A.M., AND TUESDAY, 1:30 P.M.

TECHNICAL EXHIBITS—BALLROOM, BALLROOM FOYER, RENAISSANCE ROOM, AND GALERIA ROOM, BILTMORE HOTEL

WOMAN'S AUXILIARY

to the

CALIFORNIA MEDICAL ASSOCIATION

Twenty-Second Annual Convention, April 27-29, 1952

Headquarters: Biltmore Hotel, Los Angeles

MRS. STANLEY R. TRUMAN
President

MRS. RALEIGH W. BURLINGAME
President-Elect

Convention Chairman: MRS. E. VINCENT ASKEY

REGISTRATION

Sunday, April 27—9:00 a.m. to 4:00 p.m.
Monday, April 28—8:30 a.m. to 4:00 p.m.
Tuesday, April 29—8:30 a.m. to 12 noon

SUNDAY, APRIL 27

8:00 a.m.—Executive Committee Meeting, President's Suite, Biltmore Hotel.

10:00 a.m. — Pre-Convention Board Meeting, Conference Room 5, Biltmore Hotel.

3:00 p.m.—Opening Session of the California Medical Association. Report of the year's work of the Woman's Auxiliary by the President, Mrs. Stanley R. Truman. All Auxiliary members and doctors' wives are invited to attend. Biltmore Theatre.

MONDAY, APRIL 28

9:30 a.m.—First General Session of the Twenty-second Annual Convention, Ballroom, Alexandria Hotel, 210 West Fifth Street. Mrs. Stanley R. Truman, President, presiding.

4:00 - 6:00 p.m.—Reception, honoring Mrs. H. Gordon MacLean, wife of the President of the California Medical Association. All doctors' wives and their husbands are invited. Rendezvous Room, Biltmore Hotel.

7:30 p.m.—California Medical Association dinner and dance, honoring the President, Dr. H. Gordon MacLean. Biltmore Bowl, Biltmore Hotel.

TUESDAY, APRIL 29

9:00 a.m.—Second General Session of the Twenty-second Annual Convention, Ballroom, Alexandria Hotel. Mrs. Stanley R. Truman, President, presiding.

1:00 p.m.—Luncheon, honoring Mrs. Stanley R. Truman, Mrs. Raleigh W. Burlingame, the State Advisory Board and Past State Presidents. Cocoanut Grove, Ambassador Hotel, 3400 Wilshire Boulevard.

3:30 p.m.—Post-Convention Board meeting, Conference Room 5, Biltmore Hotel. Mrs. Raleigh W. Burlingame, presiding.

Technical Exhibits

The Association is again fortunate in having a record number of technical exhibits, this year covering an even greater variety of products and services than ever before.

Exhibits will be located in the Ballroom and Foyer, at the south end of the Galeria, in the Renaissance Room at the north end, and in the Galeria Room, which can be entered from both the main Galeria and the north Galeria opposite the Music Room.

Among the technical exhibits on display will be the newest developments in pharmaceuticals and biologicals, in services for physicians and in allied fields of value to all. Each exhibitor has been careful to send selected personnel to the meeting, to insure the most competent display and explanation of all goods and services.

All those registered at the meeting are welcome in the exhibit rooms. Time spent there will be time well spent, both for the gathering of new information and for supplementing the scientific knowledge from the scientific sessions.

Ample time has been provided between scientific sessions to permit all registrants to visit the exhibits. Please do so, for your own sake primarily but likewise to show your appreciation for these exhibitors, whose contributions make this meeting possible each year.

A list of exhibitors and their displays is given below.

Room and Booth No.

ABBOTT LABORATORIES **Ballroom Foyer—3, 4**
North Chicago, Illinois

Abbott will present two animated exhibits—one on DAYALETS, a tablet containing eight synthetic vitamins, plus vitamin B_{12}; the other on ABBOCILLIN 800M, which offers 800,000 units of penicillin per cc. The DAYALETS exhibit shows *Mr. Fishy Taste* waving goodbye from a box car to illustrate the absence of fish-oil taste, burp and allergic reactions in that product. In the ABBOCILLIN 800M exhibit, a moving line shows the high initial peak obtained from a single 1-cc. dose, followed by sustained blood levels for a 48-hour period.

A. S. ALOE COMPANY **Ballroom Foyer—2**
Los Angeles

Steeline examining and treatment room furniture will be on display, as well as the Aloe line of Physical Therapy Equipment, bearing the approval of the Council on Physical Therapy of the American Medical Association.

The latest instruments of interest to the Physician and Surgeon will also be available for your inspection.

AMES COMPANY, Inc. **Ballroom—29**
Elkhart, Indiana

The Ames DIAGNOSTIC KIT will be featured. This small kit, measuring 3 x 9 inches, contains CLINITEST—a test for urine-sugar, BUMINTEST—a test for albumin, ACETEST—a test for acetone, and HEMATEST—a test for occult blood. No extra reagents, equipment or accessories are needed. This kit is designed for the physician's office, small laboratory, hospital floor use, etc. The Ames representatives will be demonstrating these tests.

Ames Company representatives will be glad to discuss DECHOLIN and DECHOLIN SODIUM, the standard hydrocholeretic agents for the treatment of biliary tract diseases.

THE ARMOUR LABORATORIES
Chicago, Illinois **Galeria Room—99**

You are cordially invited to attend The Armour Laboratories Exhibit where our representatives will be pleased to discuss with you ACTHAR GEL, The Armour Laboratories' brand of Adrenocorticotropic hormone; TRYPTAR; the Armatinic Products; the Crystamin products; and Thyroid.

Room and Booth No.

AYERST, McKENNA & HARRISON, Ltd.
New York, New York **Ballroom—49**

Physicians attending the California Medical Association convention are cordially invited to visit the Ayerst booth. Our representatives will be happy to answer your inquiries relative to "Antabuse" or other Ayerst specialties.

BABY DEVELOPMENT CLINIC
Chicago, Illinois **Galeria Room—96**

Baby Development Clinic presents the psychological and emotional aspects of early infant feeding in visual as well as printed form. Ideal for use of doctors, nurses, teachers and others who are in contact with expectant parents, medical students or nurses in training. *Maternity Counselling Service* . . . a courtesy service available to doctors for their maternity patients . . . relieves doctors of discussing layette needs and other preparations for home and baby. No charge or obligation to either doctor or patients. Supported by firms included in exhibit.

THE BAKER LABORATORIES, Inc.
Cleveland, Ohio **Ballroom Foyer—15**

Baker's Modified Milk (liquid and powder) and Varamel (liquid) are made from Grade A Milk (U. S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats, and by the addition of vitamins and iron.

Baker's Modified Milk is a completely prepared formula, including the carbohydrate, and only water needs to be added.

Varamel is a formula base to be varied by the physician with additions of carbohydrate, and water to meet the exact needs of the individual infant.

For more information, we cordially invite you to visit our booth.

DON BAXTER, Inc. **Ballroom Foyer—10**
Glendale

Well-informed Baxter representatives will discuss several of the newest developments in parenteral therapy. New Baxter intravenous solutions in Vacoliter containers will be displayed. New and special Baxter blood transfusion equipment will be discussed and demonstrated. You'll see the remarkable new Baxter plastic intubation tube and oxygen catheters for greater patient comfort.

Room and Booth No.

BECTON, DICKINSON & CO. **Ballroom—46**
Rutherford, New Jersey

We will have on display a general line of hypodermic syringes and needles, clinical thermometers, diagnostic equipment and Ace Bandages. We will feature the new Dynafit Syringe with clear glass barrel, and the full-footed, full-length Ace Elastic Hosiery.

M. J. BENJAMIN **Renaissance—84**
Los Angeles

M. J. Benjamin will be at Booth No. 84 (near the Fifth Street entrance) to say hello to old friends and to display samples of what we are making these days in the way of trusses, orthopedic appliances, and surgical corsets. Our place of business is right across the Park from the Biltmore Hotel. We occupy the entire Sixth Street side of the fifth floor of the Paramount Theater Building. We welcome you to Los Angeles.

THE BORDEN COMPANY **Ballroom—32**
New York, New York

Borden representatives will be more than pleased to discuss a new powdered infant food with you. BREMIL is a completely modified milk in which nutritionally essential elements of cows' milk have been adjusted to supply the nutritional requirements of infants deprived of human milk. Clinical, x-ray and laboratory evidence with a large group of infants fed exclusively on Bremil proved conclusively its efficacy as an infant food. Bremil is a new phase in infant feeding.

Likewise exhibited will be our long-established products for infant feeding: Biolac, Mull-Soy, Dryco, Beta Lactose, Klim, and Merrell-Soule special milks.

THE BORDEN FOOD PRODUCTS COMPANY
San Francisco **Galeria Room—104**

All Delegates and members are invited to our booth for a refreshing cup of Borden's Pure Coffee.

New, interesting and helpful literature on Borden's Evaporated Milk, and high Protein Starlac will be available.

BOYLE & COMPANY **Ballroom—58**
Los Angeles

This, our Silver Anniversary Year, we will be featuring our well-known Hematinic line; but we will also exhibit Deimal, our multiple vitamin-mineral combination; Boyle Pre Natal line; Opidice, an adjunct in the control of obesity; and the Boyle Antibiotic Sensitivity Testing Sets, all well known to the profession through our professional promotion program.

A. M. BROOKS COMPANY **Galeria Room—105**
Los Angeles

We are happy to again greet our many friends in Booth No. 105 where we are featuring the outstanding diathermy of the year, the RAYTHEON (radar) MICROTHERM. We shall also feature other electro-medical equipment, such as the TECA line of Low Volt equipment, Edin electrocardiograph and encephalograph, Cardiotron electrocardiograph, ADC Audiometers, AMBCO Hearing Amplifiers, Ultrasonic equipment, and many physical therapy items such as Vasculators, Whirlpool Bath, Quartz and Infra Red Lamps, and Foredom Vibrators.

Competent salesmen on hand to demonstrate all equipment.

Room and Booth No.

BROWN & WILLIAMSON TOBACCO CORPORATION **Ballroom Foyer—21**
Louisville, Kentucky **Galeria Room—112**

Members of the California Medical Association are cordially invited to visit the two attractive exhibits of the Brown & Williamson Tobacco Corporation. One exhibit will be devoted to KOOL mildly mentholated cigarettes, America's most refreshing smoke, and the other exhibit to VICEROY filter tip cigarettes. Both brands of cigarettes are of particular interest to the medical profession. Souvenirs will be presented to all members who register at the KOOL and VICEROY booths.

BURROUGHS WELLCOME & COMPANY
Tuckahoe, New York **Renaissance—83**

A UNIQUE ANTIBIOTIC—'AEROSPORIN' brand Polymyxin B Sulfate will be featured. 'Aerosporin' is available in topical, parenteral and oral preparations, and destroys Pseudomonas aeruginosa (B. pyocyaneus) and most other gram-negative bacilli.

'POLYSPORIN' brand Polymyxin B—Bacitracin Ointment will also be displayed. 'Polysporin' contains 10,000 units of 'Aerosporin' (equivalent to 1 mg. of Polymyxin Standard) and 500 units of Bacitracin per gram. It eliminates both gram-negative and gram-positive organisms. 'Polysporin' is especially effective against pyogenic skin infections, it rarely sensitizes and resistance rarely develops.

CAMEL CIGARETTES **Renaissance—64**
New York, New York

CAMEL Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking CAMEL Cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking CAMELS."

S. H. CAMP & COMPANY **Renaissance—73**
Jackson, Michigan

S. H. Camp & Company, Jackson, Michigan, will feature the new Camp Varco Pelvic Traction Belt in addition to displaying a complete line of Camp Anatomical Supports for prenatal, postnatal, visceroptosis, sacro-iliac, hernia, and other specific conditions. Experts from the Camp staff will be in attendance to answer questions pertaining to the scientific application of these supports and to advise regarding the availability of them in authorized service departments of stores throughout the country.

ELDON H. CANRIGHT COMPANY, Inc.
Glendale **Galeria Room—103**

All eight of our prescription specialty products, each representing the latest scientific developments in major fields of therapy, will be on exhibit at our booth. Professional descriptive literature will be available and courteous representatives will be present.

CARNATION COMPANY **Ballroom Foyer—26**
Los Angeles

The Carnation Company cordially invites you to visit the Merry-Go-Round exhibit at Booth No. 26. This interesting and unique display shows that Carnation Milk is the first choice for infant feeding. Valuable literature on additional uses of Carnation Vitamin D Evaporated Milk for child feeding and general diet purposes will be available for distribution.

Room and Booth No.

CIBA PHARMACEUTICAL PRODUCTS, Inc.
Summit, New Jersey **Renaissance—60**

Ciba Pharmaceutical Products, Inc., Summit, New Jersey (Booth No. 60), cordially invites you to visit their booth which will feature ITRUMIL, an antithyroid compound with a different mode of therapeutic action in Hyperthyroidism.

Representatives in attendance will be very pleased to discuss this and other Ciba products and to provide you with material for clinical investigation.

THE COCA-COLA COMPANY **Renaissance—61**
Los Angeles

Ice-cold Coca-Cola served through the cooperation and courtesy of the Coca-Cola Bottling Company of Los Angeles and The Coca-Cola Company.

COMMERCIAL SOLVENTS CORPORATION
New York, New York **Galeria Room—97**

CSC Pharmaceuticals, a division of Commercial Solvents Corporation, will feature its new product COMPENAMINE, the new hypoallergenic form of Penicillin. Available to date in five dosage forms: Aqueous suspension in ten dose, one dose, and the disposable syringe; COMPENAMINE in oil in ten dose, and the disposable syringe. Other dosage forms to be added presently. You are cordially invited to visit our booth and discuss these products with our representatives.

CONTINENTAL MEDICAL BUREAU, Agency
Los Angeles **Renaissance—76**

Continental Medical Bureau of Los Angeles in Booth No. 76 invites you to stop by and talk with them regarding any personnel needs in the medical field. Complete data available on general practitioners or Diplomates of Special Boards who seek new locations. See them also if you wish to dispose of equipment or an established practice. Locations recommended. Up to date information on all areas of California as well as on Western and Southwestern States. Information gladly. (Helen Buchan, Director)

CUTTER LABORATORIES **Ballroom Foyer—19**
Berkeley

CUTTER LABORATORIES, Booth No. 19, features immunizing and therapeutic agents for children's diseases. "Alhydrox" absorbed toxoids and combined vaccines, as well as Human Blood Fractions, such as Hypertussis, Immune Serum Globulin, and the new Cutter Albumin Shock Kit, will be on display.

Educational literature for your patients will be available to you.

The complete line of Cutter Saftiflask solutions, including Invert Sugar, and expendable equipment for administration will be shown. Additionally, blood bottles and new all-plastic pressure sets will be on display.

F. A. DAVIS COMPANY **Renaissance—69**
Philadelphia, Pennsylvania

For the first time, before the California Medical Association, there will be displayed the recently completed *Cyclopedia of Medicine, Surgery and Specialties*. It's all new . . . and looseleaf! Also see the medical and scientific textbooks of vital interest in today's practice of medicine.

DESITIN CHEMICAL COMPANY
Providence, Rhode Island **Galeria Room—109**

Desitin Ointment, the pioneer in external cod liver oil therapy, combines crude high potency Norwegian cod liver oil, zinc oxide, and talcum in a modified lanolin petrolatum base. Owing to its content of high natural vitamin A and D concentration and unsaturated fatty acids, Desitin Ointment alleviates pain and relieves itching promptly. It promotes granulation and epithelization. Desitin Ointment is not liquefied at body temperature nor decomposed by secretions. Desitin Ointment forms a perfect protection for the skin. Indications: Postoperative dressings, slow healing wounds, indolent chronic varicose ulcers, burns of all degrees, lacerations, bed sores, hemorrhoids and fissures.

Desitin Powder, a unique, dainty medicinal toilet powder, contains crude cod liver oil, zinc oxide, magnesium oxide and talcum. Uses: As of Desitin Ointment.

DEVEREUX SCHOOLS **Galeria Room—114**
Santa Barbara

Large color photos of the school campus and leather, ceramic and jewelry items made by the children and featured in the Devereux Schools Exhibit.

The Devereux Foundation offers "tailor made" education for children who are unable to adjust themselves in the public schools—either because of emotional, academic or intellectual problems.

In a boarding school setting, the Devereux Schools offer the finest educational and clinical facilities plus an outstanding staff of specialists to assist physicians to meet the needs of their school age patients who are failing in their home communities.

THE DIETENE COMPANY **Renaissance—71**
Minneapolis, Minnesota

Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.

MERITENE, the economical and palatable whole protein supplement, and DIETENE, the "Council-Accepted" reducing supplement, will be on display.

DOHO CHEMICAL CORPORATION
New York, New York **Renaissance—70**

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative—gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring RECTALGAN, the liquid topical anesthesia for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

ENDO PRODUCTS, Inc. **Ballroom Foyer—16**
Richmond Hill, New York

Our staff will be very happy to discuss with our many friends the diversified ENDO line, featuring HYCODAN, the anti-tussive of choice, PERCODAN and NUCODAN, the new analgetics for moderate pain, MESOPIN, the selective antispasmodic, and NORODIN, our psycho-motor stimulant and anti-depressant.

Our booth will be in charge of Mr. H. L. Wellington, our West Coast Branch Manager, and our detail-man who calls on you will be very happy to welcome you to our exhibit.

C. B. FLEET COMPANY, Inc. **Ballroom—51**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to visit Booth No. 51. Increasingly, during the past fifty years, to the

Room and Booth No.

medical profession, sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous solution of the two U.S.P. sodium phosphates.

ROLAND J. GAUPEL COMPANY
Los Angeles **Renaissance—63**

The Roland J. Gaupel Company's exhibit this year will feature many West Coast manufactured products—a new type treatment table; utility table; folding Pakatable; plastic front illuminator for x-ray; illuminator with drip pan attachment; a film marker which reduces the patient's history to one-fourth regular size, thereby increasing the possibility of more detailed description; laminated x-ray protective screen; two-speed treatment or darkroom timer; automatic RJG cassette holder, and various other items.

GEIGY PHARMACEUTICALS
New York, New York **Galeria Room—115**

The Geigy exhibit will feature TROMEXAN, the new, widely acclaimed, *Council Accepted*, oral anticoagulant that provides more rapid action, shorter effect, and a greater margin of safety than other oral anticoagulants. Also on display will be URAX Cream, a new long-acting, non-sensitizing, antipruritic and scabicide; and PANPARNIT indicated for symptomatic relief of Parkinson's Disease.

GENERAL ELECTRIC COMPANY, X-Ray Department
Milwaukee, Wisconsin **Ballroom—24**

The General Electric Company, X-Ray Department, manufacturers of complete x-ray equipment from portable diagnostic to 2,000,000-volt therapy apparatus — electrocardiograph—diathermy—x-ray accessories and supplies. GE's service is available to you at more than 60 offices throughout the United States and Canada. Why not discuss your particular problems with us?

GERBER PRODUCTS COMPANY
Fremont, Michigan **Ballroom—48**

The GERBER BABY greets physicians and their guests at the California Medical Association meeting. Symbolizing the best in baby foods, he will continue pioneering research in the field of applied infant nutrition. His picture on "Starting" cereals, Strained and Junior foods and Gerber-Armour meats for babies is your assurance of uniform high quality.

JOHN F. GREER COMPANY
Oakland **Ballroom—55**

The John F. Greer Company will feature the Greer Colostomy Compact, a complete post-operative appliance for the colostomy patient. This equipment is the result of 23 years' experience in the exclusive manufacture of colostomy appliances.

Miss Jayne Greer will be at the booth to discuss with doctors any special problems they may have in connection with colostomy equipment.

THE HARROWER LABORATORY, Inc.
Glendale **Galeria Room—98**

The Harrower exhibit will feature Prulose Complex liquid, a new dosage form of moist bulk activated with concentrate of California prunes fortified with a new laxative principle (diacetylhydroxyphenylisatin) which has been identified as the active laxative principle of prunes.

Room and Booth No.

H. J. HEINZ COMPANY
Pittsburgh, Pennsylvania **Ballroom—56**

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the addition to Heinz Baby Food line—Pre-Cooked Barley Cereal? New Junior Foods are Sweet Potatoes, Chocolate Pudding, Butterscotch Pudding, and Macaroni-Tomato-Beef and Bacon.

HOFFMANN-LA ROCHE, Inc.
Nutley, New Jersey **Ballroom—33**

Two exceptionally interesting products will be featured at the Roche exhibit. One product is ASTEROL, a new antifungal drug which is of impressive value in ringworm of the scalp, athlete's foot and other fungus infections of the hair and skin. ASTEROL is available as an ointment, as a tincture, and in powder form. The other product is GANTRISIN, the more soluble sulfonamide which has a wider antibacterial spectrum. GANTRISIN is highly effective in the treatment of systemic and urinary tract infections.

Why not stop at the Roche booth where members of the field staff will be glad to discuss these and other Roche specialties with you.

HOLLAND-RANTOS COMPANY, Inc.
New York, New York **Ballroom—53**

You are cordially invited to inspect the Holland-Rantos display feature: Time-tested Koromex Diaphragms, Jelly, Cream, etc., for dependable conception control; Nylmerate Jelly and adjuvant Nylmerate Solution for effective low-cost treatment of vaginal trichomoniasis, moniliasis, leukorrhea. Representatives will welcome the opportunity to talk with you about H-R products of special interest to you.

IRWIN, NEISLER & CO.
Decatur, Illinois **Galeria Room—106**

Irwin, Neisler and Company is pleased to exhibit at your convention for the first time and hopes that it may be the beginning of a long and pleasant association. We will be calling your attention to DAINITE and VERENTERAL, two new products of research to serve your practice.

LAKESIDE LABORATORIES
Milwaukee, Wisconsin **Galeria Room—116**

Lakeside exhibit will display ethical pharmaceutical specialties deriving from the later developments in medicine. Professional representatives will be on hand to discuss these medications and their use.

LANTEEN MEDICAL LABORATORIES, Inc.
Evanston, Illinois **Ballroom Foyer—18**

Lanteen Medical Laboratories, Inc., extend a cordial invitation to visit their Booth No. 18. Representatives will discuss the improved LANTEEN technique, a dual method of contraception based on the use of LANTEEN Flat Spring Diaphragm and LANTEEN Spermatocidal Jelly.

Two new ethical pharmaceuticals are also being featured: Alkagel, a pioneer antacid which provides prompt and prolonged neutralization of gastric acidity and relief from peptic ulcer; and Vodine, iodine in a special ointment base which makes possible rapid bactericidal action for skin, surface wounds, abrasions, etc., without burning. Samples and literature describing each of these products are available.

Room and Booth No.

LEDERLE LABORATORIES
New York, New York **Ballroom Foyer—12**

You are cordially invited to visit our exhibit in Booth No. 12, where you will find representatives who are prepared to give you the latest information on Lederle products.

LIBBY, McNEILL & LIBBY **Renaissance—66**
San Francisco

You are cordially invited to stop and discuss the merits of Libby's Homogenized Baby Foods and sample Libby's Tomato Juice, which has proved to be so popular at previous meetings.

ELI LILLY AND COMPANY **Ballroom—54**
Indianapolis, Indiana

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in Booth No. 54. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

J. B. LIPPINCOTT COMPANY **Renaissance—81**
Philadelphia, Pennsylvania

J. B. Lippincott presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. LORILLARD COMPANY **Galeria Room—108**
New York, New York

P. Lorillard Company exhibit will display our leading brands of cigarettes, smoking tobaccos and cigars.

LOV-É BRASSIERE COMPANY
Hollywood **Ballroom—35**

We invite you to inspect our highly specialized line of therapeutic breast supports which enable the physician to prescribe remedial support for specific breast conditions. Each LOV-É Brassiere is custom-fitted inch-by-inch to your patient's personal measurements . . . and in exact accordance with your instructions. Special brassieres for pre-natal, post-partum, atrophic, hypertrophic and mastectomy. LOV-É Corrective Brassieres are available in leading department stores and corset shops through the West. Our representative will be very happy to answer any questions.

M & R LABORATORIES **Galeria Room—113**
Columbus, Ohio

Our representatives for Similac and Cerevim will be most happy to discuss with you the merits and use of our products in the field of infant and child nutrition.

MARLYN COMPANY Inc. **Ballroom—37**
Los Angeles

Marlyn Company Inc. cordially invites you to visit Booth No. 37 where a staff of our representatives will be on hand to furnish information on our products. Test-Estrin, the original product of combined steroid in physiological ratio, will be featured.

Room and Booth No.

THE S. E. MASSENGILL COMPANY
San Francisco **Renaissance—75**

Our exhibit will feature Obedrin tablets and the 60-, 10-70 diet for weight reduction. Also, Khelisem tablets, a highly potent coronary dilator.

McNEIL LABORATORIES, Inc. **Ballroom—43**
Philadelphia, Pennsylvania

Members of the California Medical Association are cordially invited to visit our booth, No. 43, Mr. Hugh A. Harley in charge. Products to be featured are Butisol Sodium, Butisol-Belladonna, Syndrox Hydrochloride, Syntil and Cinbisal.

MEAD JOHNSON & COMPANY **Renaissance—72**
Evansville, Indiana

Mead Johnson & Company will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, Poly-Vi-Sol, Tri-Vi-Sol and Ce-Vi-Sol; Fer-In-Sol, a palatable, highly concentrated solution of ferrous sulfate. Also Mulcin, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four Pablum cereals, including Barley and Rice.

MEDCO PRODUCTS COMPANY
Tulsa, Oklahoma **Galeria Room—110**

The MEDCOTRON Stimulator, for the stimulation of enervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Stop by our booth for a personal demonstration.

THE MEDICAL CENTER AGENCY
San Francisco **Ballroom Foyer—5**

This agency offers long experience in filling the needs of Physicians seeking professional affiliations. Interviews are confidential and are given our individual attention.

We are the center of placement activity for physicians and all other medical personnel. "Positions Throughout the West."

THE MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana **Ballroom Foyer—14**

Specializing exclusively in professional protection since 1899, The Medical Protective Company provides representation at Booth No. 14 familiar with all the complexities of professional liability by special training and long experience. An answer to your problems in the Doctor-Patient relationship is yours for the asking.

MERCK & CO., Inc. **Galeria—113**
Rahway, New Jersey

MERCK & CO., INC. is featuring CORTONE (Cortisone Merck). Among the conditions in which CORTONE has produced striking clinical improvement are: rheumatoid arthritis and related rheumatic diseases; bronchial asthma; eye diseases including non-specific iritis, iridocyclitis and uveitis; skin diseases including cases secondary to drug reactions. CORTONE is supplied in a saline suspension for parenteral use; in tablets for oral use; and in an ophthalmic suspension and ophthalmic ointment. Representatives at the MERCK booth will be glad to provide information on CORTONE as well as other MERCK medicinal preparations such as Antibiotics, Cobione (Crystalline Vitamin B_{12}), Neo-Antergan, Urecholine Chloride, and Vinethene.

Room and Booth No.

THE WM. S. MERRELL COMPANY
Cincinnati, Ohio **Ballroom—38**

For prompt, effective and comfortable relaxation of gastro-intestinal smooth muscle spasm Merrell presents BENTYL Hydrochloride.

BENTYL is a high milligram potency non-narcotic anti-spasmodic with two-fold musculotropic and neurotropic action. Effective therapeutically without atropine-like side actions in functional gastrointestinal disorders.

BENTYL is particularly suited for prolonged administration without habituation or increased tolerance.

MILLER SURGICAL COMPANY
Chicago, Illinois **Ballroom Foyer—17**

Sole manufacturers of Rudolph V. Gorsch, M.D., illuminated stainless steel rectal scopes. Other items of interest include our electro-scalpel which provides a unit for office, hospital, and out-call use. It is thoroughly practical for all minor and light major surgery and comes complete with monopolar electrodes for cutting, coagulating, desiccating, dehydrating, bloodless biopsies and fulgurating in general work. Also displayed will be a complete line of illuminated and magnifying diagnostic units which have attracted the attention of so many doctors in general practice as well as in special fields.

THE C. V. MOSBY COMPANY
San Francisco **Ballroom Foyer—1**

You will find at the Mosby Booth No. 1, our newest and latest books. Should you be interested in recent medical literature, be sure to "stop by" and look over anything that might be of interest to you.

THE NATIONAL DRUG COMPANY
Philadelphia, Pennsylvania **Ballroom—52**

The National Drug Company, pioneer in the clinical application of resin therapy, will feature RESION, an intestinal adsorbent; RESINAT, a polyamine exchange resin for the treatment of peptic ulcer; and NATRINIL, a cation exchange resin for the control of edema. Trained representatives will be in attendance to discuss our resin preparations and other specialties: ACTH, Ammivin, AVC Improved, Benat, DTP Vaccine, Natolone, as well as any of National's vast array of pharmaceutical and biological products.

THE NESTLE COMPANY, Inc. Renaissance—74
Colorado Springs, Colorado

You are cordially invited to visit the Nestle Booth No. 74 for information on Arobon, a new clinically tested, proven product, prepared from specially processed Carob flour and designed for the treatment of non-specific diarrhea. Literature and information on Nestle's Milk products will be available.

THE NETTLESHIP COMPANY Renaissance—85
Los Angeles

Specialists in the field of malpractice insurance since 1924 and administrators of the official programs of eight professional Associations, this organization will have representatives present qualified to discuss with the doctor patient relationship problems.

Specimen Patient Consent and Authority Forms will be "free for the asking," as well as other valuable Claims Prevention material.

Information as to Accident and Sickness Insurance for the doctor on the extraordinarily favorable basis made possible by Society Group Policies will also be available.

Over 9,000 physicians and surgeons and 300 hospitals are insured by this firm specializing in doctors' insurance problems.

Room and Booth No.

ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey **Ballroom—42**

ORTHO cordially invites you to visit their exhibit at Booth No. 42. The exhibit will include the ORTHO line of obstetrical and gynecological pharmaceuticals.

Featured will be the well-known ORTHO preparations for conception control. Representatives will be on hand to greet you and discuss any of the ORTHO products with you.

PACIFIC COAST MEDICAL BUREAU, Agency
San Francisco **Ballroom—57**

The Pacific Coast Medical Bureau of San Francisco will have representatives in Booth No. 57. This Bureau, now in its eighth year in California, has contacts throughout the State. Prompt and confidential services to doctors seeking new associations or locations or to Clinics or Groups needing additional personnel. Files available on general practitioners and Diplomates of all Specialty Boards. Drop by Booth No. 57 and chat with Maria Gizzi, Director.

PARKE, DAVIS & CO. Ballroom—40
Detroit, Michigan

Medical Service Members of the Parke, Davis & Company Staff will be in daily attendance at our commercial exhibit for consultation and discussion of the various products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Hypnotics, and others will be featured. You are most cordially invited to visit our exhibit with the assurance that your personal interest will indeed be very much appreciated.

PELTON & CRANE COMPANY Ballroom—67
Detroit, Michigan

Pelton and Crane will exhibit in Booth No. 67 their latest sterilizers and autoclaves, featuring their new F. L. No. 2 Speed Autoclave. Competent representatives will gladly assist you in selecting the proper equipment for your office or hospital.

PET MILK COMPANY Ballroom Foyer—7, 8
San Francisco

Pet Milk Company presents a miniature model of an evaporated milk plant. This exhibit offers an opportunity to obtain information about the production of Pet Milk, and the time-saving Pet Milk services available to doctors. Miniature Pet Milk cans given to persons who visit the Pet Milk booth.

CHARLES PFIZER & COMPANY, Inc.
Brooklyn, New York **Ballroom—34**

Terramycin, newest of the broad spectrum antibiotics forms a dramatic central feature of the display of Charles Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

PHILIP MORRIS & CO., Ltd., Inc. Ballroom—44
New York, New York

Philip Morris and Company will show the results of research on irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

Room and Booth No.

PICKER X-RAY **Ballroom—36**
Los Angeles

Picker X-Ray of Los Angeles and Sicular X-Ray of San Francisco will feature new and interesting x-ray accessories. Radiographic pictures taken with the new technics will also be shown.

RIKER LABORATORIES, Inc. **Renaissance—82**
Los Angeles

Riker Laboratories will feature Veriloid Intravenous Solution, which makes available to the physician, for the first time, a means of reducing the arterial tension to any desired level by the intravenous route. Regardless of the severity or cause of the hypertension, Veriloid Intravenous can, within a matter of minutes, reduce the pressure to normal or near-normal limits, and so maintain it for hours or days. Veriloid (a chemically and biologically standardized alkaloidal extract from Veratrum viride) is also available in tablet form, for oral administration, as supplementary and follow-up therapy to Veriloid Intravenous Solution.

RITTER COMPANY, Inc. **Galeria Room—107**
Rochester, New York

You are cordially invited to stop by and see the new line of Ritter Treatment and Examination Tables. A representative will be on hand to assist you in present problems.

A. H. ROBINS COMPANY, Inc.
Richmond, Virginia **Ballroom Foyer—11**

The A. H. Robins Company exhibit is featuring PHENAPHEN and PHENAPHEN with CODEINE, "the complete analgesics"; and ENTOZYME, the "tablet-within-a-tablet" for comprehensive digestive therapy. Robins Medical Service Representatives welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

SANBORN COMPANY **Renaissance—62**
Cambridge, Massachusetts

Visitors at the Sanborn Company Booth, No. 62, will have the opportunity for acquaintance with the "Viso family" of direct-writing recorders for diagnosis, teaching, and research; the famous Viso-Cardiette, leader among direct-writing electrocardiographs; the Viso Recorder, for single channel recording without electrocardiography; and the Twin and Poly-Visos, for two and four channel recording of a wide variety of biophysical phenomena.

Also on display will be such useful supplementary instruments as the Sanborn Electromanometer and Ballistocardiograph; and attachments for registration of heart sounds (for timing), pulse waves, and pneumograms.

For the clinician interested in metabolism testing, the display will also feature the Sanborn Metabulator, with its revolutionary "all enclosed" design and "table-top" operation.

SANDOZ PHARMACEUTICALS
San Francisco **Renaissance—78**

This display will feature Cafergot for the oral treatment of migraine and other types of headache; DHE-45 (Dihydroergotamine) for the parenteral treatment of migraine; Mesantoin and Hydantal for the treatment of epilepsy; Methergine, an oxytocic; several cardiac glycosides including Cedilanid, Digilanid and Strophosid; and Hydergine (CCK-179) for essential hypertension and peripheral vascular disease.

Room and Booth No.

W. B. SAUNDERS COMPANY **Ballroom—59**
Philadelphia, Pennsylvania

We invite all doctors attending the meeting of the California Medical Association to visit our exhibit where we will display a complete line of our books including Hyman's *Integrated Practice of Medicine*, Hyman's *Progress Volume*, Conn's *1952 Current Therapy*, *Surgical Practice of the Lahey Clinic*, Cecil's *Specialties in General Practice*, Meschan's *Atlas of Normal Radiographic Anatomy*, *American Illustrated Medical Dictionary*, Salter's *Textbook of Pharmacology*, Bland's *Clinical Uses of Fluids and Electrolytes*, Howorth's *Textbook of Orthopedics*, American College of Surgeons' *Surgical Forum*, Campbell's *Clinical Pediatric Urology*, Braasch and Emmett's *Clinical Urography*, and many other new books and new editions.

R. L. SCHERER COMPANY **Ballroom Foyer—27**
Los Angeles

We will exhibit an x-ray unit, surgical instruments, diagnostic instruments, and other items to interest the profession. We will also have on display the FCC approved Diathermy. You are cordially invited to visit our booth.

SCHERING CORPORATION **Ballroom—30**
Bloomfield, New Jersey

Members of the California Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Schering representatives will be present to discuss with you these products as well as other products of our manufacture.

G. D. SEARLE & CO. **Renaissance—77**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed.

Other time-proven products of Searle research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

SHARP & DOHME **Ballroom Foyer—23**
Philadelphia, Pennsylvania

Research data relative to the potentiating effect of the antibiotics, bacitracin and tyrothricin, are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B_{12} are also of major interest. Our representatives will welcome your visit.

SMITH-DORSEY **Ballroom—25**
Lincoln, Nebraska

Smith-Dorsey is featuring: Doraxamin, an improved treatment for peptic ulcer; Dorsaphyllin, a buffered aminophylline possessing better gastric tolerance; Pasara (Para-Aminosalicylate Sodium), an adjunct therapy in tuberculosis; H. P. S. Sixty, a well tolerated protein supplement; and many Council Accepted injectables.

You are cordially invited to make the Smith-Dorsey booth your headquarters.

Room and Booth No.

SMITH, KLINE & FRENCH LABORATORIES
Philadelphia, Pennsylvania **Ballroom—31**

'Pen-Eff'—a *new form* of oral penicillin. 'Pen-Eff' is an *effervescent* penicillin tablet containing 250,000 units of crystalline potassium penicillin G. The tablet is dissolved in water and taken orally as a sparkling, pleasant-tasting liquid. 'Pen-Eff' contains 300% more buffering alkali than any other penicillin tablet, and it is equally effective on a fasting or non-fasting stomach. 'Pen-Eff' is effective with only 3 doses daily.

E. R. SQUIBB & SONS **Ballroom Foyer—22**
New York, New York

E. R. Squibb & Sons look forward to seeing you at the California Medical Association meeting.

In support of the active scientific program planned for you, the Squibb representative will present information on related products. Service leaflets will be available to you to take or to be sent to your home upon request.

Please visit the Squibb booth.

J. W. STACEY, Inc. **Ballroom Foyer—13**
San Francisco

Stacey's, established over a quarter of a century ago by members of the medical profession, provides the doctor in the West with an efficient source for all medical books of all publishers. At Booth No. 13 you will find displayed the latest books on medicine, surgery and the specialties. You are cordially invited to browse at your leisure.

STAYNER CORPORATION **Ballroom Foyer—9**
Berkeley

Stayner cordially invites you to visit our booth where we will exhibit VIT-A-STAY, the latest development in Vitamin A therapy which affords better absorption, freedom from regurgitation and sensitivity. VIT-A-STAY tablets contain no oil of any kind to emulsify. We will also feature Stayner Placebo Capsules for barbiturate withdrawal therapy and demonstrate our fast-acting, water-soluble D.A.S. tablets for control of obesity. We will be happy to discuss any of the other 120 products of our manufacture or to merely have you use our booth as your headquarters.

THE STUART COMPANY **Ballroom Foyer—6**
Pasadena

The Stuart Company will feature several of its nutritional specialties with special emphasis on three new items which have just been introduced.

TRAVENOL LABORATORIES, Inc.
Morton Grove, Illinois **Ballroom—28**

The new drug, Pyromen® is a sterile, nonprotein, nonanaphylactogenic bacterial component in a colloidal dispersion for intravenous or intradermal use. Pyromen produces a generalized stimulation of the reticulo-endothelial system and increased adrenocortical activity. Pyromen is a successful new drug which has proved its usefulness in the treatment of allergies and dermatoses.

UNITED LABORATORIES **Renaissance—65**
Pasadena

Clinical and basic laboratory research are the cornerstones of United Laboratories' Specialty products. Collaboration with investigators of medical institutions for the past three years has helped develop the clinical usage of ACTH. ACTROPE, United's highly purified Corticotropin (ACTH), will be featured.

Room and Booth No.

Also displayed will be LIPO-B. Investigations of lipotropic and oxytropic combination therapy in the treatment of atherosclerosis show promise. LIPO-B is indicated in the treatment of fatty infiltration of the liver, a common factor in generalized malnutrition, alcoholism and diabetes mellitus.

Bru-Col, combining mixed oxidized bile acids for stimulative therapy in the bile complex, will also be featured.

U. S. VITAMIN CORPORATION **Ballroom—39**
New York, New York

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research laboratories.

Three pharmaceutical firsts . . . Vi-Syneral Vitamin Drops—multivitamins in drops solution; Vi-Syneral Injectable—multivitamin parenteral solution and now Vi-Aqua Therapeutic—aqueous multivitamins in capsules . . . for more rapid absorption, greater therapeutic activity, shorter treatment time.

We cordially invite you to our booth for detailed literature and professional samples.

THE UPJOHN COMPANY **Galeria Room—111**
Kalamazoo, Michigan

It is the sincere desire of The Upjohn Company to make some definite contribution to the success of the 1952 meeting. Stop by at Booth No. 111 to relax and discuss topics of mutual interest.

VAISEY-BRISTOL SHOE CO., Inc.
Rochester, New York **Galeria Room—100**

Representatives will explain the diagnostic value of Jumping Jack shoes and the criteria for determining whether the early walking child is strengthening his foot by proper foot function or is possibly damaging it by walking poorly.

Jumping Jack shoes are not "corrective" shoes but representatives are equipped to discuss therapeutic wedging which may be installed in the shoes by prescription.

Of especial interest is the Sincock system of determining the precise amount of correction needed to rectify a faulty gait. Many doctors have lauded Dr. Sincock's empirical method as "genius."

VARICK PHARMACAL CO., Inc.
New York, New York **Renaissance—80**

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with professional representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

WALKER LABORATORIES, Inc.
Mount Vernon, New York **Renaissance—79**

PRECALCIN, the complete prenatal product supplying all essential vitamins and minerals, will be exhibited. PRECALCIN is unique in that the capsules contain a dry powder fill with no fish liver oils, thereby providing excellent tolerance and patient appeal. Other outstanding preparations will also be featured and our representatives present will be glad to discuss all aspects of current therapy in their particular fields.

WALTERS SURGICAL COMPANY
Los Angeles **Renaissance—68**

We will display H. G. Fischer X-ray equipment and shortwave diathermies and the latest developments in medical equipment.

Room and Booth No.

WESTERN SURGICAL SUPPLY COMPANY

Los Angeles **Renaissance—50**

All types of Surgical and Medical supplies, including surgical instruments; Hamilton furniture; sterilizers; autoclaves, enamel ware and stainless steel ware; physiotherapy equipment; laboratory supplies and equipment, and electrical equipment will be shown at our booth.

WESTINGHOUSE ELECTRIC CORPORATION

Los Angeles **Galeria Room—102**

We will be showing the Westex, a versatile new x-ray table suitable for private practice and hospital use. We will also show other x-ray accessories. You are cordially invited to stop by and discuss your x-ray problems with our representatives.

WESTWOOD PHARMACEUTICALS

Buffalo, New York **Ballroom—41**

Westwood will display its vaginal anti-infective Westhiazole Vaginal and Gentia-Jel in the new improved plastic single-dose disposable applicators which greatly simplify the administration of intravaginal jelly. The use of gentian violet in the treatment of monilial vaginitis has been made possible in the office and in the home with these plastic disposable applicators. The ease and convenience in the use of these applicators will be demonstrated at the Westwood booth.

Westwood also features its new, greatly improved Lowila Cake. It's smooth, slippery, gives oceans of suds and compares with soap in stability. We will give physicians a cake for personal use at the hotel, to prove that it gives the use-satisfaction of soap but is kind to sensitive skin.

WHITE LABORATORIES, Inc.

Kenilworth, New Jersey **Ballroom Foyer—20**

Dienestrol, the potent, orally effective synthetic estrogen, will be on display. Dienestrol differs chemically from stilbestrol and other synthetic estrogens. It is unique in its action and is one of the best tolerated of all orally effective synthetic estrogens.

WINTHROP-STEARNS, Inc. Ballroom—47

New York, New York

Winthrop-Stearns, Inc., New York, invite you to visit Booth No. 47, where the following products will be featured—MUCILOSE COMPOUND TABLETS, the new physiologic bulk laxative; MYTOLON, new synthetic skeletal muscle relaxant for use as adjunct to surgical anesthesia; MILIBIS, new, virtually non-toxic amebacide; ARALEN, effective antimalarial, also specific for extra-intestinal (hepatic) amebiasis; FERGON PLUS, a combination of the important anti-anemia factors, Vitamin B_{12}, Folic Acid, ferrous gluconate and ascorbic acid. It is designed specifically for the prophylaxis and therapy, iron deficiency and macrocytic anemias; LEVOPHED, the true vasoconstrictor hormone of the adrenal medulla, for the maintenance of blood pressure in shock and other acute hypotensive states.

WYETH INCORPORATED Ballroom—45

Philadelphia, Pennsylvania

Wyeth Incorporated extends to you a cordial invitation to visit the Wyeth booth at the April meeting of the California Medical Association, where trained representatives will be pleased to discuss and supply literature concerning many outstanding therapeutic agents. Featured in this exhibit will be THIOMERIN, a recently developed safe mercurial diuretic, and ADJUDETS, Wyeth's pleasant-to-take troche form of dextro-amphetamine phosphate and essential vitamins which curb the appetite and maintain good health in the obese patient. Other widely prescribed ethical specialties which may be of interest to you, such as IRONATE, SEVETOL, SEBELLA, BEPLETE with Belladonna, PHENERGAN, SULFOSE, AMPHOJEL, PONDETS and TUBEX will be displayed.

PRE-CONVENTION REPORTS

Officers - Councilors - Committees - County Societies

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the Members of the California Medical Association and the House of Delegates:

During the past several years the C.M.A. has been carrying on and developing a public relations program. During the early stages the work was of necessity of the general educational campaign type. This has been so effective that in the past two years most of our efforts have been directed toward the development of down-to-earth grass roots public relations, right at the level of the doctor and patient.

The psychological study of the individual doctor-patient relationship by Dr. Ernest Dichter has been finished and is available in printed form. A practical digest of the Dichter report, "Doctor and Patient," has been excellently prepared by Mr. Rollen Waterson and Mr. William Tobitt, Executive Secretaries of Alameda-Contra Costa and Orange County Medical Associations, respectively. Great credit is due these men for their most able efforts.

A department of public relations of the C.M.A. has been set up during the past year and is under the direction of Mr. Ed Clancy. He is assisted by Mr. Glenn Gillette in the North and by Mr. Jerry Pettis in the South. This department will assist all county medical associations desiring aid in developing a public relations program. It should also be most helpful in carrying on a closer liaison with the Woman's Auxiliary.

Your President, ably assisted by the President-elect, has visited the county medical associations of the state. I have endeavored to discuss the importance of the doctor-patient relationship, and stimulate a deep interest in further work along these lines. Mr. John Hunton, Mr. Ben Read, and Mr. Ed Clancy have aided greatly in helping to present a well rounded program of public relations and legislation. Their efforts are gratefully acknowledged.

The Woman's Auxiliary to the C.M.A. has been most impressive. It is truly doing a great work along many lines. Their joint meetings with the leaders of other woman's groups, at which medical problems and progress are discussed by capable speakers, are outstanding examples of fine public relations. Under the tireless, enthusiastic leadership of their President, Mrs. Stanley Truman, the Auxiliary has advanced greatly in the past year. I am sure all the members of the C.M.A. join with me in thanking the Woman's Auxiliary for their great work.

The C.M.A. is fortunate in having a progressive, intelligent, hard-working and faithful Council. This group of men, through its officers and committees, quietly carry on the affairs of the C.M.A., most capably and often with very little credit. Theirs is a true love of their profession.

Our legislative and legal affairs, under the guidance of Dr. Dwight Murray, Mr. Ben Read, and Mr. Howard Hassard, have as usual been most capably handled. CALIFORNIA MEDICINE is considered one of the best medical journals in the country. The Editor, Dr. Dwight Wilbur, and his staff are to be complimented.

The business affairs of the C.M.A. are in good condition, and we are indeed fortunate to have such a well-run office, under the direction of Mr. John Hunton.

It has been a great honor and a privilege to be your President, and I wish to thank all members of the C.M.A. and all county medical associations for their graciousness shown me during the past year.

Sincerely,

H. GORDON MACLEAN, *President*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

In performing his assigned duties in the visitation program covering the northern component county associations, your President-elect has been more than ever impressed with the vast geographic expanses and the productive resources of the state of California. The county societies are well organized and eagerly interested in furthering the aims and ideals of the profession. Attendance upon these meetings was for the most part excellent, and this was all the more noteworthy because in some of the more sparsely settled areas such attendance required travel in some instance of a hundred miles or more. On several occasions, the Woman's Auxiliaries met with us, adding not only charm and hospitality, but indicating a commendable awareness of medicine's problems and an ardent desire to aid in their solution.

The California Medical Association is indeed to be congratulated upon the high caliber of those in its employ. Mr. John Hunton, Executive Secretary, Mr. Ben Read, Executive Secretary of the Public Health League, and Mr. Ed Clancy, Director of Public Relations, were warmly welcomed wherever they went. Mr. Clancy's new associates, Mr. Glenn W. Gillette for the North, and Mr. Jerry L. Pettis for the South, demonstrated an ability to discuss the Association's activities in a manner that augurs well for the future.

The Association's new grass-roots public relations program was explained and received hearty endorsement. "A Biologic Interpretation of Economics" was presented in which stress was placed upon fundamental natural law as the only dependable basis for a productive and expanding economic system. The incurable fallacies of collectivism and their historic failures were summarized, and the appropriate functions of government from a biologic viewpoint defined.

Respectfully submitted,

L. A. ALESEN, *President-elect*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

The adoption of the new Constitution and By-Laws at the last Annual Session has made some changes in the operation of the House of Delegates.

1. At the present time it is mandatory that the House of Delegates meets twice a year, the Annual Session to be held in the spring and the Interim Session to be held in the fall. Chapt. V, Sect. 1(a) (By-Laws).

2. Resolutions and other new business may be introduced at either regular session but shall not be acted upon until the *next* regular session. Provision is made for the introduction of emergency resolutions which may be passed at the current session provided that a two-thirds affirmative vote is secured. Chapt. V, Sect. 7(c) (By-Laws).

The question immediately arises as to the mechanism for proposing an emergency resolution. It is our opinion that time will be saved if the Delegate upon proposing such a resolution shall declare it to be an emergency measure. It would then be received and processed by the appropriate reference committee. This resolution, upon being brought before the House for action, would require a two-thirds vote for adoption.

The usual resolutions and other new business, not designated as emergency, must be held for action until the next regular session. Section 9 of the By-Laws provides that Reference Committees shall make their report and that these shall be mailed to each delegate at least 30 days prior to the meeting of the House of Delegates. This new procedure will give each delegate an ample opportunity to study the proposed legislation.

With this new machinery in action there will need to be some continuity within the Reference Committees from session to session. At least one member should be held over in order to present the material from the last session.

The first Interim Session proved of great value, not alone for the volume of business that was transacted but in providing a trial run of our new By-Laws. Each delegate that participated has earned the thanks of the Association.

Respectfully submitted,

DONALD L. CHARNOCK, *Speaker*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

The Vice-Speaker has attended all meetings of the Council during the year and assisted the Speaker in the conduct of the interim meeting of the House of Delegates at Los Angeles in December. He has attended numerous meetings of special committees to which he has been appointed by the President and the Council.

Respectfully submitted,

H. A. RANDEL, *Vice-Speaker*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

The Council procedure during the current year has followed closely that adopted for the last two years and as has been reported to you has consisted in the usual periodic Council meetings during which the mornings have been devoted to committee reports and business of a routine nature, the lunch period to hearing business representatives and other groups who wished to appear before the Council and the afternoons to the consideration of new problems.

If, at times, members have been inconvenienced by being requested to appear during certain hours, it was due to the attempt to follow this schedule as closely as possible.

The individual items of business have appeared in the Council minutes so that every member has had the opportunity to follow the deliberations of the Council if he wished.

As during all prior years, the presence and assistance of Dr. Murray, Mr. Hassard, Ben Read, Ed Clancy and John Hunton have been invaluable to the Council.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman of the Council*

REPORT OF THE VICE-CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

As Vice-Chairman of the Council I have attended all the meetings of the Council, and have aided the Chairman whenever any assistance was requested.

Respectfully submitted,

DONALD D. LUM, *Vice-Chairman of the Council*

Report of the Council

To the President and the House of Delegates:

The Council rendered a report to the Interim Session of the House of Delegates, held on December 1-2, 1951. This report has been printed in the Journal and reference is hereby made to it as a progress report covering the activities of the Council for the Association year from May to December 1951.

Only principal action taken by the Council since the date of the earlier report was the appropriation of $40,000 to the C.P.S. Study Committee, as authorized by the House of Delegates.

At this writing the Council is scheduled to hold another meeting on February 10, 1952, and, in accordance with usual custom, the Council will plan to meet the day before the start of the 1952 Annual Session.

It is with sorrow that the Council calls attention to the death on December 20, 1951, of Dr. John Ball, Councilor from the Second Councilor District. Dr. Ball had served the Council well and faithfully and had at all times represented his constituents in a most able manner. His passing leaves a gap in the Council, to be filled by action of the House of Delegates for the term expiring with the Annual Session of 1953.

If any consequential actions are taken at the February 10 or April 26 meetings of the Council, an additional report will be made to the House of Delegates.

Respectfully submitted,

SIDNEY J. SHIPMAN, *Chairman*

REPORT OF THE CHAIRMAN OF THE EXECUTIVE COMMITTEE

To the President and the House of Delegates:

The Executive Committee has transacted business delegated to it by the Council and matters which have arisen between Council meetings and action on inter business. All such action is subject to confirmation by the Council.

I wish to thank the members of the Executive Committee for the giving of their time and wholehearted support to this work.

Respectfully submitted,

DONALD D. LUM, *Chairman*

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE C.M.A.

To the President and the House of Delegates:

The Trustees of the C.M.A. is a non-profit holding corporation, whose members are at all times members of the Council of the C.M.A. The corporation cares for the assets of the C.M.A. It has met in accordance with its articles of incorporation and its by-laws during the past year, and its financial report is printed elsewhere in this issue under the report of the Treasurer.

Respectfully submitted,

H. GORDON MACLEAN, *President*

REPORT OF THE SECRETARY

To the President and the House of Delegates:

Your Secretary was reappointed by the Council at its May 16 meeting in 1951. He has attended the meetings of the Council and the Executive Committee. He has presided at meetings of the Committee on Scientific Work and at meetings of the section secretaries in arranging for the 1952 convention. This year it was also necessary to arrange for scientific speakers for the Interim Session in December 1951.

He has attended meetings of the Committee on Postgraduate Activities and other committees appointed by the House and Council.

The minutes of the Council meetings and of the Executive Committee are prepared by the Executive Secretary and are then edited by the Legal Counsel, the Secretary and the Chairman of the Council or of the Executive Committee. These minutes are then printed in CALIFORNIA MEDICINE and they contain the routine business of the Association.

It was strongly recommended that these be read in detail by all members.

Respectfully submitted,

ALBERT C. DANIELS, *Secretary*

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your executive secretary submits his report for the past year, arranged into the divisions of authority conferred upon him by action of the Council.

1. *Administrative:* The Association's office has undergone some physical changes in the past year. Some additional space was secured and some reconstruction done in the layout of the office, toward the goal of more efficient operations. At present all operations of the official journal are concentrated in one office area and all general, administrative and public relations activities in another. The two are connected by intercommunicating telephones.

The Association has taken on one more office assistant, a secretary who divides her time between public relations and membership activities. As the membership continues to grow, however, it is apparent that a full-time assistant will soon be needed to handle this important phase of the Association's work. It is worthy of note that the membership of the C.M.A. has more than doubled in the past 11 years; at the same time, the imposition of annual dues by the American Medical Association has created many new problems of handling membership items. California has been fortunate to date in collecting such a high percentage of A.M.A. dues that the state has not lost any representation in the A.M.A. House of Delegates. Several other large state associations have not fared so well and are now being forced to decrease their A.M.A. representation.

The office staff, in San Francisco, now consists of the executive secretary, his assistant, an assistant to the editor, an advertising manager, an associate director of public relations and six secretaries whose combined work covers all Association activities. In the Southern California office, in Los Angeles, are located the director and an associate director of public relations. They do not have any full-time assistants but have secretarial service readily available to meet their requirements.

Other C.M.A. employees, on a part-time appointment basis, are your editor, director of postgraduate activities and his part-time secretary, and a medical director of the Cancer Commission.

The headquarters office is in very good physical condition. All equipment is modern and adequate for the work to be done. The office arrangement, while not ideal, is efficient and a workmanlike job is being produced by all concerned.

2. *Membership:* In accordance with the requirements of the By-Laws, the following account of active membership in the component societies, as of November 1, 1951, is given:

MEMBERSHIP—November 1, 1951

Alameda-Contra Costa	988
Butte-Glenn	55
Fresno	229
Humboldt	57
Imperial	37
Inyo-Mono	10
Kern	123
Kings	23
Lassen-Plumas-Modoc	19
Los Angeles	4,585
Marin	80
Mendocino-Lake	27
Merced	39
Monterey	115
Napa	51
Orange	200
Placer-Nevada-Sierra	56
Riverside	112
Sacramento	257
San Benito	9
San Bernardino	235
San Diego	506
San Francisco	1,432
San Joaquin	152
San Luis Obispo	47
San Mateo	239
Santa Barbara	150
Santa Clara	346
Santa Cruz	72
Shasta	24
Siskiyou	16
Solano	60
Sonoma	100
Stanislaus	94
Tehama	10
Tulare	78
Ventura	67
Yolo	29
Yuba-Sutter-Colusa	39
Total	10,768

It is upon this count of membership that the county societies are entitled to their representation in the House of Delegates, on the basis of one Delegate for each fifty active members or major fraction thereof, with a minimum of two Delegates for each society.

The secretaries of the component societies have been most cooperative in maintaining good membership records. It is inevitable in a large membership that some errors occur, such as changes of address not keeping up with the moving members, but it is believed that a very high degree of efficiency is being maintained in such matters.

3. *Meetings:* The executive secretary has attended all meetings of the Council and of the Executive Committee. He has also attended the two meetings of the American Medical Association, serving as secretary to the California delegation. In company with either the president or president-elect of the Association, he has attended meetings of 26 county societies, together with correlated meetings of the Woman's Auxiliary and other organizations.

4. *Financial:* The Association's 1950-1951 fiscal year ended with an excess of $34,279 of expenditures over revenues, after giving effect to the $100,000 contributed to the American Medical Education Foundation. General income was about $37,000 below that of the preceding year, this drop resulting from decreased annual dues. Revenues of the official journal were up almost $26,000, the increase coming almost entirely from higher advertising revenues.

Administrative expenses of just under $148,000 were some $19,000 higher than in the previous fiscal year, while

expenditures for scientific, educational and public relations purposes were almost $75,000 higher, including the $100,000 educational contribution. Expenses of the journal were up $21,000, the bulk of this increase coming from higher printing costs for a bigger journal for more members. Further comment will be made on journal finances under a separate section of this report.

It should be borne in mind that the C.M.A. today is a much larger business operation than in former years. In the fiscal year ended June 30, 1951, the Association took in $569,334 and expended $603,613. It published a journal at a total cost of more than $10,000 monthly, it made loans totaling $70,000 to blood banks and it was able, out of current funds, to make the educational grant to the A.M.A. without disturbing the accumulated surplus funds held by the corporation, Trustees of the C.M.A.

The corporation showed a net profit of $24,749 in the past fiscal year, this resulting from $25,695 interest income from U. S. Government securities held, less operating expenses of $946. At the close of the fiscal period the corporation showed total assets of $1,087,400, consisting entirely of cash or securities. Surplus was $1,050,547 and trust accounts totaled $36,853, these including the Physicians' Benevolence Fund and the Herzstein Bequest Fund.

5. *California Medicine:* As noted above, the official journal was increased in size, circulation, revenue and expenditures last year. Circulation has now increased to the point where new and higher advertising rates have been put into effect. Production costs have mounted along with increased size and numbers, as have advertising revenues. Percentagewise, advertising sales were up 28.2 per cent for the year, from $87,130 to $111,673. Other revenues were 3.2 per cent higher, at $35,805 compared with $34,683, and expenses were 20.8 per cent higher, at $122,493 compared with $101,402. Net profit for the 1951 fiscal year was $24,984, or 22.8 per cent higher than the $20,411 net of the preceding year.

In addition, CALIFORNIA MEDICINE continued to hold its eminent position among medical publications. It continued to be widely quoted nationally and some of its editorial features have been emulated by other journals. Its advertising pages are constantly screened by a committee of members who operate under a stringent set of regulations devised to keep the advertising pages clean in all respects. This committee, now under the chairmanship of Dr. Matthew N. Hosmer of San Francisco, is one of the hardest-working committees in the Association and is deserving of much praise for its effective and devoted duty.

6. *Public Policy and Legislation:* The executive secretary has continued to work with the Committee on Public Policy and Legislation, supplementing the activities of those who devote their entire time to this field. The 1951 legislative session was the longest on record and produced the highest number of proposed legislative acts in the history of California. The Association was able to secure enactment of some legislation of great importance and to oppose successfully the passage of proposals deemed inimical to the best interests of the profession.

7. *Public Relations:* The executive secretary serves as chairman of the Advisory Planning Committee, into whose hands the Council has entrusted the formation and activation of a public relations program for the Association. This program has been developed, approved in principle by the Council and turned over to the committee for inauguration, under the direct supervision of the Executive Committee.

Under the present program Mr. Ed Clancy, formerly field secretary, has been named director of public relations, and Messrs. J. L. Pettis and Glenn W. Gillette named as his associates. Mr. Pettis was formerly assistant to the president of a large airlines company and Mr. Gillette served for three years as executive secretary of the Fresno County Medical Society. Under the leadership of this team, several progressive programs for county medical societies have been developed and placed in operation in various county medical societies. The public relations staff maintains constant contact with the county societies and works with them in a cooperative, not a dictatorial, fashion. It is believed that the programs now under way, including establishment of telephone answering services, advertising to publicize such services and to delineate the position of a Doctor of Medicine, and radio programs developed as a public service, will do much to improve the general feeling of the public toward the profession.

These programs have been discussed at county medical society meetings attended by a public relations staff member, the executive secretary and one of the officers of the Association.

8. *Annual Session:* The 1952 Annual Session is now well into the planning stage and it is believed that a most successful meeting will result. Technical and scientific exhibitors have shown a strong interest in the session and the scientific program is most complete. A mention should be called to the fact that the Association is again about to outgrow the meeting facilities available in California. It is becoming increasingly difficult to secure the space needed for scientific and business meetings and technical and scientific exhibits in the hotels and other buildings in the state. Because of crowded convention schedules, many of the larger hotels cannot accommodate meetings on less than two years' notice. Since the Council is authorized to select the meeting place, this matter will be taken up with that body.

9. *Conclusion:* The executive secretary wishes to express heartfelt thanks to the officers and Councilors and to the numerous committee chairmen and members with whom he has been privileged to work. All these have been extremely cooperative and helpful and a debt of gratitude is due them. Likewise, the public relations staff, the legal counsel and the executive secretary of the Public Health League of California have been constantly cooperative in working for the good of the Association in the strictest teamwork. The office staff must again be thanked deeply for its continued help in all matters and its willing attitude in taking on whatever job is presented. Without such cooperation from all sides the work of the Association would be seriously impeded.

Respectfully submitted,

JOHN HUNTON, *Executive Secretary*

REPORT OF THE EDITOR

To the President and the House of Delegates:

Sharing to some extent in what appears to be a general trend, CALIFORNIA MEDICINE last year received fewer unsolicited manuscripts for consideration than it did in the previous year. Editors of other state journals who attended the State Medical Journal Conference held last November in Chicago noted a dwindling supply of manuscripts from sources other than meetings of medical organizations. Those who spoke on the subject indicated a drought for their publications somewhat more severe than that which the journal of the California Medical Association has experienced. The editor of one regional journal said that in the preceding year only about one-tenth of the scientific articles printed by the publication he edits were reports that had not previously been delivered at formal medical meetings.

CALIFORNIA MEDICINE's experience in this regard is indicated in the following tabulation of the numbers of manuscripts received from the Annual Session and from other sources in the last three years:

	Annual Session		Other		Totals	
	Rec'd	Accepted	Rec'd	Accepted	Rec'd	Accepted
1949.....	176	87	131	73	307	160
1950.....	179	82	114	66	293	148
1951.....	138	89	79	42	217	131

To budding authors, and to mature ones too, the implication is plain: There is space waiting for good, well-written timely articles on subjects of medical interest. As one of the functions of CALIFORNIA MEDICINE is to reflect the practice of medicine in the state as a whole, special consideration is given to articles submitted from sources outside the metropolitan and teaching centers. The "market" for reports of difficult or unusual cases is particularly good.

Although it is anticipated that the inventory of articles for publication soon will be seasonally increased by the acceptance of some of the papers presented at the forthcoming Annual Session, the stock on hand has been reduced during the past year in order to shorten to the practicable minimum the time-lag between acceptance and publication of manuscripts.

Among the entirely pleasant aspects of your editor's job is the great help given by those with whom he works. Throughout the year he feels, and herein once a year can but inadequately publicly express, his gratitude to the members of the Editorial Board, who read, criticize and winnow the manuscripts submitted. His thanks go also to many anonymous others who have helped in the production of your official journal—to those who have written material on assignment, to the reviewers of books, and to those who have given their time to special reviews of manuscripts. To Robert Edwards, assistant to the editor, and Mrs. Barbara Rooney of the office staff of CALIFORNIA MEDICINE go special thanks for an excellent job without which the journal could not be maintained in the present state of excellence.

Respectfully submitted,

DWIGHT L. WILBUR, *Editor*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates:

The Legal Department submits the following brief summary describing the nature of its activities during the year 1951 and up to the time of the preparation of this report, January 1952:

During the past year we have attended all meetings of the House of Delegates, Council, and Executive Committee, as well as various meetings of standing committees and other agencies of the Association.

We have also prepared and submitted opinions on a wide variety of subjects, as requested by the Association or its officers or component societies, including disciplinary procedural questions, questions of interpretation of the principles of medical ethics, legal problems connected with operation of blood banks, the relationship of corporation and other lay agencies to the practice of medicine, and a number of questions arising out of pending legislation or newly enacted laws.

In addition to our advisory services, we have also undertaken, at the instance of the Council, the following:

1. *Legislation:*

During the first six months of 1951 the Legislature was in regular session and during such time we assisted the Committee on Public Policy and Legislation in the presentation of bills to legislative committees, opposition of bills inimical to the public health, and aided the committee in the interpretation and analysis of the several hundred bills affecting the practice of medicine.

One bill that was sponsored jointly by the California Medical Association and the State Board of Medical Examiners, and which successfully passed the Legislature and was signed by the Governor, merits special comment. It was Assembly Bill 2672 authored by Mr. Arthur H. Connolly, Jr., of San Francisco, and it added Section 2013 to the medical practice act chapter of the Business and Professions code. It became law on 22 September 1951. It provides a definition of the words "diagnose" and "diagnosis," including specifically the use of mechanical devices or machines for the purpose of representing to any person any conclusion with respect to such person's physical, mental or nervous condition. It is sufficiently broad to include all diagnostic procedures in the fields of radiology and pathology, and we believe puts at rest the contention that has been advanced from time to time that the taking of an x-ray film is a "business function" separable from the "professional function" of interpreting the film.

In addition, the new Section 2013 indirectly incorporates psychological services into the definition of the practice of medicine by exempting from the term "diagnosis" the performance of psychological services on referral from a licensed physician and surgeon. Under general rules of statutory construction, a specific exemption necessarily implies that the general provisions would have covered the subject except for the specific exemption. Applying this principle to Section 2013, the performance of psychological services by one who is not a licensed physician and surgeon and who is not acting on referral from a licensed physician and surgeon, constitutes the unlawful practice of medicine.

Section 2013 also specifically exempts testing and guidance programs in schools and private industry.

2. *Malpractice cases:*

As amici curiae we have appeared in the case of *Pearce vs. Linde et al*, now pending before the District Court of Appeal, First Appellate District, Division Two. This case involves an extremely important question of law, i.e., whether a physician practicing in another state (Nevada) is legally qualified to act as an expert witness in malpractice actions in California. It is our contention that out-of-state physicians are not sufficiently familiar with the standards of practice in California to qualify as expert witnesses in this state. At the time of preparing this report, the Court has not reached a decision.

3. *Anti-trust litigation:*

We submitted a verbal report to the House of Delegates at the interim session in December 1951, with respect to the current status of the anti-trust suits pending in the states of Washington, Oregon and Oklahoma, and in the county of San Diego. We assume it is unnecessary to repeat the report presented at that time.

Since our December report, the case of *United States vs. Oregon State Medical Society et al* has been orally argued before the United States Supreme Court. There are two basic questions involved before the Supreme Court. First, whether or not the operation of prepayment plans (other than insurance companies) involves interstate commerce, so as to be within the scope of the Sherman Act; and, second, whether or not the opposition of physicians in the state of Oregon to lay-owned "hospital associations" and their support of prepaid service plans owned and operated by medical societies, has constituted a restraint of trade. During the oral argument, all of the justices of the Supreme Court have asked frequent questions of counsel for the

Government and counsel for the Oregon State Medical Society and other defendants. The tenor of the questions indicates that the members of the court are keenly interested and intend to lay down a guide for the application of the Sherman Act to prepaid medical service plans. It must be borne in mind that the American Medical Association case arose in the District of Columbia, where the Sherman Act is applicable to all forms of trade or commerce, irrespective of the presence or absence of interstate commerce. The Oregon case is the first one to arise under that portion of the Sherman Act that is limited to restraints of trade or monopolies affecting interstate commerce.

Likewise since the December meeting, the action pending in San Diego, *Complete Service Bureau et al vs. San Diego County Medical Society et al,* has been orally argued before the Trial Court. The argument consumed three and one-half days and was completed January 31, 1952. A decision by the Trial Court may be expected within the next two months.

4. *Unlicensed prepaid medical care plans:*

For many years so-called prepaid medical and hospital plans have attempted to operate in this state without complying with the insurance laws. Their existence has been the subject of intense legislative inquiry, and from time to time remedial legislation has been proposed, but, due to conflicting points of view, such legislation has failed. Within the past year and a half the Insurance Commissioner has proceeded against the largest of these unregulated plans. He has taken action under those sections of the Insurance Code that permit the Commissioner to take control and possession as conservator or liquidator, of insurance companies that are insolvent or otherwise in violation of the insurance laws.

The Commissioner first proceeded against American Independent Medical & Health Association, whose headquarters were in San Diego, and his action in taking possession and liquidating the company was upheld by the San Diego Superior Court.

In November 1951, the present Insurance Commissioner, Mr. John R. Maloney, took possession of the business and assets of Union Mutual Medical Association and Pacific Health Service Association, both having headquarters in Los Angeles. Union Mutual Medical Association did not oppose the Commissioner's action, but Pacific Health Service Association filed an application in the Los Angeles Superior Court to recover possession of its properties from the Commissioner, on the ground that it was operating just like California Physicians' Service. In fact, Pacific Health Service Association had diligently copied the articles of incorporation and by-laws of C.P.S., as well as its contract forms, physician member certificate forms, fee schedule, and other literature. However, it had neither obtained a license from the Insurance Commissioner, nor had it complied with Section 9201 of the Corporations Code (the enabling act under which C.P.S. operates). After a hearing before Judge Nourse, of the Superior Court in Los Angeles, an opinion was rendered upholding the Insurance Commissioner and specifically finding that Pacific Health Service Association had not accomplished anything in the eyes of the law by making itself "look like" C.P.S.

The decision in the Pacific Health Service Association case will be of great importance in the future control of unlicensed prepaid medical service plans that do not comply with either the insurance laws or Section 9201 of the Corporations Code. The Insurance Commissioner's enforcement power has been firmly established, and is bound to act as a deterrent to lay promoters desiring to sell medical service contracts to the public without benefit of initial capital or any accountability for the use of funds collected.

There have been other services performed by the Legal Department which will be reported orally to the House of Delegates.

As we have concluded our report in previous years, we wish to reiterate our constant desire to serve the medical profession to the best of our ability.

Respectfully submitted,

PEART, BARATY & HASSARD,
General Counsel

REPORT OF THE TREASURER

To the President and the House of Delegates:

The Treasurer of the Association was elected by the Council on May 16, 1951. The actual duties of this office are performed by the office staff at 450 Sutter Street, San Francisco, California.

The accounts are audited by independent accounting firms. The receipts and expenditures of all funds are checked and the presence of cash, securities and other assets is certified to.

Submitted herewith is the series of accounts prepared from reports submitted by John F. Forbes & Company covering the fiscal year July 1, 1950, to June 30, 1951.

Members are urged to study these accounts for a true picture of the Association's financial position.

Respectfully submitted,

ALBERT C. DANIELS, *Treasurer*

(Balance sheets and statements of income and expenditure appear on following pages.)

CALIFORNIA MEDICAL ASSOCIATION

Balance Sheet, June 30, 1951

ASSETS

Cash		$117,395.09
Accounts Receivable		5,027.81
Loan Receivable—New Mexico Physicians' Service	$11,750.00	
Less reserve	10,750.00	
Remainder		1,000.00
Other Loans Receivable	$70,000.00	
Less reserve	70,000.00	
Remainder		
Investment in U. S. Treasury Bills (at cost)		199,196.00
Cash Surrender Value of Life Insurance Policies		4,844.53
Trust Fund (contra)		13,010.71
Furniture and Fixtures (at nominal value)		1.00
Deferred Charges		1,974.95
Deposits		2,261.48
Total		$344,711.57

LIABILITIES

Accounts Payable		$ 19,613.55
Accrued Expenses:		
American Medical Association—Delegates' and other expenses	$ 5,317.39	
Organization expense	2,590.63	
Committees' and sundry	4,432.66	
Pay roll taxes	336.14	
Total		12,676.82
Trust Account—Physicians' Benevolence Fund (contra)		13,010.71
Deferred Income—Prepaid Advertising		491.22
Surplus, Exhibit A		298,919.27
Total		$344,711.57

EXHIBIT A

Surplus Credits:		
Reduction in reserve for New Mexico Physicians' Service loan		$ 3,750.00
Increase in cash surrender value of life insurance policies		2,632.93
Other		49.98
Total		$ 6,432.91
Remainder		$ 27,845.95
Surplus Charges:		
Expenses applicable to a prior period		$ 862.00
To set up reserves for loans to blood banks		70,000.00
Total		$ 70,862.00
Decrease in Surplus for the Year		$ 98,707.95
Surplus, July 1, 1950		397,627.22
Surplus, June 30, 1951		$298,919.27

CALIFORNIA MEDICAL ASSOCIATION

Income and Expenditures for Fiscal Year Ended June 30, 1951

INCOME

	Fiscal Year Ended June 30 1951	1950	Increase Decrease
1. Membership Dues (exclusive of Journal Allocation)	$395,808.56	$438,208.68	$ 42,400.12
2. Annual Session	18,805.00	18,850.00	45.00
3. Miscellaneous Income	4,865.41	.....	4,865.41
4. Interest Income	2,377.61	1,442.71	934.90
Total Revenues	$421,856.58	$458,501.39	$ 36,644.81

EXPENDITURES

Administrative:			
5. A.M.A. Delegates' Expense	$ 20,302.26	$ 13,583.25	$ 6,719.01
6. Annual Session Expense	23,249.89	21,885.44	1,364.45
7. Employees' Annuities	3,608.52	1,529.72	2,078.80
8. Council—Executive Committee	2,367.59	2,708.15	340.56
9. Equipment Expense	2,014.65	1,393.40	621.25
10. Legal Department	16,268.10	9,092.28	7,175.82
11. Los Angeles Office Expense	2,109.51	2,028.42	81.09
12. Miscellaneous Expense	237.11	1,524.00	1,286.89
13. Office Supplies and Expense	4,598.44	4,057.30	541.14
14. Organization Expense	10,394.45	8,770.25	1,624.20
15. Rent	5,630.28	5,630.28	.....
16. Telephone and Telegraph	1,967.83	2,258.40	290.57
17. Payroll Tax Expense	1,519.86	1,114.71	405.15
18. Pensions	4,260.00	4,620.00	360.00
19. Postage	900.12	935.34	35.22
20. Salaries:			
(a) Administrative	30,238.62	28,725.00	1,513.62
(b) Clerical	10,133.48	9,569.68	563.80
21. Secretarial Conference	1,117.26	1,205.12	87.86
22. Travel Expenses:			
(a) Officers	219.10	1,385.23	1,166.13
(b) Council—Executive Committee	6,040.71	4,795.95	1,244.76
(c) Secretary—Executive Secretary	.....	1,189.36	1,189.36
23. Woman's Auxiliary	750.00	750.00	.....
Scientific, Education and Public Relations:			
24. Department of Public Relations	73,661.92	124,713.81	51,051.89
25. Public Policy and Legislation	67,863.31	62,289.98	5,573.33
26. Cancer Commission	11,004.07	26,329.59	15,325.52
27. Committees' Expense	27,842.65	19,204.94	8,637.71
28. Los Angeles Special Appropriation	24,003.56	.....	24,003.56
29. Postgraduate Committee	12,972.91	10,459.99	2,512.92
30. Contributions to Benevolence Committee	10,562.50	10,359.75	202.75
31. Donations to Medical Libraries	5,281.24	5,179.86	101.38
32. American Medical Education Foundation	100,000.00	.....	100,000.00
Total Expenses	$481,119.94	$387,289.20	$ 93,830.74
Surplus or *Loss*	59,263.36	71,212.19	130,475.55
California Medicine Surplus	24,984.50	20,410.71	4,573.79
Combined Surplus or *Loss*	$ 34,278.86	$ 91,622.90	$125,091.76

CALIFORNIA MEDICINE

Official Journal of the California Medical Association

INCOME AND EXPENDITURES FOR THE FISCAL YEAR ENDED JUNE 30, 1951

INCOME

	Fiscal Year Ended June 30 1951	1950	Increase Decrease
1. Advertising Sales	$111,672.70	$ 87,129.51	$ 24,543.19
2. Subscriptions (Non-Members)	2,452.89	2,064.53	388.36
3. Subscriptions Allocated from Dues	32,943.00	32,133.00	810.00
4. Reprint Sales (Net)	408.90	485.75	76.85
TOTAL REVENUES	$147,477.49	$121,812.79	$ 25,664.70

EXPENDITURES

5. Printing	$ 82,492.46	$ 66,755.37	$ 15,737.09
6. Illustrations	1,721.82	1,210.61	511.21
7. Advertising Sales Expense	10,779.73	8,889.86	1,889.87
8. Adv. Discounts and Collection Expense	1,974.32	1,487.73	486.59
9. Addressograph Expense	1,816.98	1,803.08	13.90
10. Postage and Mailing	4,362.02	3,979.84	382.18
11. Rent	1,956.00	1,956.00	----------
12. Telephone and Telegraph	1,161.71	801.29	360.42
13. Salaries	15,480.25	14,292.17	1,188.08
14. Office Supplies and Sundry Expense	747.70	226.13	521.57
TOTAL EXPENSES	$122,492.99	$101,402.08	$ 21,090.91
Surplus	$ 24,984.50	$ 20,410.71	$ 4,573.79

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

(A California Corporation)

BALANCE SHEET, JUNE 30, 1951

ASSETS

CASH (including Trust Funds)	$ 22,400.24
INVESTMENTS (including Benevolence Fund Investments)	1,065,000.00
TOTAL	$1,087,400.24

LIABILITIES

TRUST ACCOUNTS:			
Benevolence Fund		$ 30,832.78	
Morris Herzstein Bequest Fund		5,743.29	
Total			$ 36,576.07
ENDOWMENT FUND			276.74
SURPLUS:			
Contributed Surplus		$882,915.99	
Earned Surplus:			
Balance, June 30, 1950	$142,382.19		
Net Income for year, Exhibit B	24,749.25	167,631.44	
Total			1,050,547.43
TOTAL			$1,087,400.24

EXHIBIT B

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

STATEMENT OF INCOME FOR THE YEAR ENDED JUNE 30, 1951

INCOME—INTEREST ON BONDS		$25,694.86
EXPENDITURES:		
Premium on bonds purchased	$378.13	
Audit fee	300.00	
Custodian fee	178.75	
Miscellaneous	88.73	
TOTAL		945.61
NET INCOME		$24,749.25

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

San Diego County

To the President and the House of Delegates:

This is the first report of the First Councilor District, San Diego County, under the new constitution.

The growth of the San Diego County Medical Society has been great in the past ten years. The present active membership is 529 members and 60 applicants, representing an increase of almost 300 per cent in ten years.

With increase in size, there is an increase in problems and responsibilities.

During the past year, with the aid of the California Medical Association, the San Diego Blood Bank has been established and successfully operated as a member of the California Blood Bank Association. At the present time, this bank is supplying all of the civilian needs of San Diego County, and is actively engaged in the Armed Forces Blood program.

The civilian hospital bed shortage in this district will be greatly relieved with the building of a new 150-bed general hospital, which will be associated with a 50-bed annex, devoted to the care of children.

I have attended the Council meetings, the minutes of which have been duly published in CALIFORNIA MEDICINE.

It is my sincere desire to correlate the activities of the state and county societies.

Respectfully submitted,

FRANCIS E. WEST, *Councilor,*
First District

SECOND COUNCILOR DISTRICT

Imperial, Inyo, Mono, Orange, Riverside and San Bernardino Counties

To the President and the House of Delegates:

The visit of President-elect Lewis A. Alesen to the Inyo-Mono County Medical Society and those of President H. Gordon MacLean to the other more southern county societies in the District have been well received and it is generally felt that these visitations are of great benefit not only to the membership but also to the members of the Woman's Auxiliary.

The second annual session of the Southern Counties Regional Medical and Surgical Institute in the Arrowhead Springs Hotel at San Bernardino July 17, 18, 1951, presented a diversified program of great merit. Too much credit cannot be given Dr. Edward C. Rosenow and the working members of his committee. Dr. C. A. Broaddus, the Director of Postgraduate Activities, is to be particularly commended for his fine efforts in arranging these regional meetings over the state.

The November meeting of our local society was arranged and sponsored by the local unit of the American Cancer Society. This lay organization is doing a fine piece of work and should be encouraged by the scientific organizations. An annual meeting of this kind in all societies in the district would result in mutual benefit to both organizations.

Probably nothing has stimulated more interest in medicine on the part of the laity than the recent Clinical Session of the A.M.A. held in Los Angeles. The television and radio broadcasts of the speeches of Senators Taft and Byrd have brought favorable comment from nearly all of our patients. Again Whitaker and Baxter should be congratulated for arranging this fine presentation. A great interest has also been evidenced in the operative surgery televised.

The Council continues to function effectively under the able chairmanship of Dr. Sidney J. Shipman. The published reports and proceedings of the meetings are already in your possession in CALIFORNIA MEDICINE.

Respectfully submitted,

JOHN D. BALL,* *Councilor*
Second District

* Dr. Ball died December 20, 1951.

THIRD COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

As a freshman member of the Council I have been agreeably pleased with observing intimately the functioning of the governing body of our association. Every item is painstakingly studied and debated and outside experts are freely called upon, so that every phase of every problem can be viewed in the best light. I feel that the members of our association can feel very comfortable about the operations of our headquarters, and can feel confidence in the integrity and fidelity of its servants.

During the year of 1951 I have attended every meeting of the Council.

Respectfully submitted,

H. CLIFFORD LOOS, *Councilor,*
Third District

FOURTH COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

This has been a year of change in which the constitutions of both the California Medical Association and the Los Angeles County Medical Association have been changed in an effort to give a wider distribution of representation to the outlying districts.

To this end, the delegates from the various districts are now elected by the members in that district. This, in the end, will give a more direct representation of the practitioner in each locality and in time the delegates themselves will recognize their responsibilities and will be more attentive to their duties.

All delegates who attend the meetings of the House of Delegates and other meetings that are held, should familiarize themselves not only with the political situations involved but also familiarize themselves with the scientific and public relations aspects of their duties.

Respectfully submitted,

J. PHILIP SAMPSON, *Councilor*
Fourth District

FIFTH COUNCILOR DISTRICT

San Luis Obispo, Santa Barbara and Ventura Counties

To the President and the House of Delegates:

As Councilor for the Fifth District I have attended all the meetings of the Council of the California Medical Association since my election.

It was my pleasure to accompany Dr. MacLean, Mr. Hunton, Mr. Read and Mr. Pettis on their visits to the local societies. These visits were well received and are a valuable means of furthering good will between the county and state societies. They acted as an additional stimulus to public relations programs in this area and as a result the basic tenets of the statewide plan will be implemented.

The blood bank, which is sponsored jointly by the societies of this district, has successfully completed its first year of operation. Early technical and administrative difficulties have been almost eliminated. The bank is cooperating with the Armed Forces blood program and the relationships with the other interested groups are gradually improving.

The officers of the local societies are cognizant of the many problems of the profession and will continue their efforts to help solve them.

Respectfully submitted,

A. A. MORRISON, *Councilor*
Fifth District

SIXTH COUNCILOR DISTRICT

Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties

To the President and the House of Delegates:

During the past year, I have attempted to attend all the meetings of the Council, and have tried to visit the different societies in the Sixth Councilor District. The Sixth Councilor District is honored by having Kern County added to our district and also pleased in having a new medical society formed in Madera County. The non-partisan Public Health League for procurement of a better government will continue to be active in the future.

Fresno County also has a new executive secretary, Mr. Roy Jensen, relieving Mr. Glenn Gillette who has been promoted to a better position with the California Medical Association.

Respectfully submitted,

NEIL J. DAU, *Councilor*
Sixth District

SEVENTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties

To the President and the House of Delegates:

This year has again seen a large increase in the number of doctors in the district. With this increase has come more and more pressure for hospital bed space. At the present time, there is an acute shortage of bed space which does not seem remediable. Although there are several new hospitals in the planning stage, costs have increased to such an extent that new bond issues are necessary to obtain needed funds for some of the contemplated district hospitals. The question of staff appointments to various hospitals is becoming a very acute problem—especially is this true of privately owned hospitals and in hospitals with closed staffs. This situation in itself may actually cause a decrease in some communities of the influx of new medical men.

Throughout the district there is now a wide dissemination of specialists in all fields, with a resultant rise in the quality of medicine available.

The Seventh District has always been interested and taken an active part in hospital and medical insurance care plans. Santa Clara County this year has developed and discussed a deductible type of policy for medical care that may be given a trial run in Santa Clara County.

The officers of the State Society have visited all the counties in this district this year and the response has been most favorable. The attendance at the meetings has been excellent and a closer liaison between the state and county societies, I feel, will definitely result from such meetings.

Two of the counties of this district now have full-time executive secretaries with the resulting improvement in the public relations program in those counties. It is hoped that at least two more of the counties will soon employ an executive secretary.

Respectfully submitted,

HARTZELL H. RAY, *Councilor*
Seventh District

EIGHTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

The year 1951 has been a very active one for the San Francisco Medical Society. In fulfillment of the provisions of the new constitution adopted in December 1950 election the society started the year with a president-elect and an assistant secretary-treasurer, as new members of the official family. The new provisions have already paid dividends in adding two able men to the leadership of our county group.

Considerable progress has been made in the discussions with representatives of union labor regarding medical care plans.

The program for better public relations carried out under our Bureau of Medical Economics has continued to pay off in the closer relationship of the doctors to their society and a better understanding between our profession and the public we serve.

A word should be said for the paid staff that has contributed so greatly to the smoothness of operations.

Finally the high point in the year was, of course, the inauguration of one of our members, John W. Cline, as president of the American Medical Association.

The year 1952, under the leadership of Stacy R. Mettier, gives promise of continued progress. The new administration has gotten off to an auspicious start.

Respectfully submitted,

M. LAURENCE MONTGOMERY, *Councilor,*
Eighth District

NINTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

Integration of Contra Costa County into the Alameda-Contra Costa Medical Association program of public service and public relations has been one of our projects during 1951.

Partial completion of this project is evidenced by newspaper advertising in central Contra Costa County during the year and by cooperation with public medical facilities toward our guarantee of "Medical Care for All, Regardless . . ." Telephone emergency systems have been placed on an organized basis and now are solving that problem in Contra Costa County.

This work, as well as the application in Contra Costa of other aspects of the original A.C.C.M.A. program, is proceeding and should be completed this year.

Work is also going forward on the study by Ernest Dichter of the physician-patient relationship with emphasis on utilization of the information which has been produced. Each step forward in this work opens new horizons of opportunity—more things that can be done toward better understanding between the doctor and the public.

The A.C.C.M.A. assisted the C.M.A. in indoctrination of the public relations field representatives who are charged with adapting the A.C.C.M.A. public service and public relations program for statewide use.

Concrete public recognition of our work was the 100-station broadcast over the NBC network in June, entitled

"All Their Powers." This was the story of the work done by the A.C.C.M.A. over the past five years, given in dramatic form, with the physicians who did the work telling their own stories.

An even more concrete result of our work, however, has been increased evidence of real understanding and approval from the press and public of our efforts and motives. These evidences appear in our excellent personal relationships with the press, and in unsolicited gratifying comments from many sources.

Respectfully submitted,

DONALD D. LUM, *Councilor,*
Ninth District

TENTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano and Sonoma Counties

To the President and the House of Delegates:

The year 1951 saw no unusual problems confronting the members of our association in my district, and, as a result, the duties of the Councilor were pleasant and not at all arduous.

Outstanding activities consisted of the usual four-county meeting of Sonoma, Marin, Napa and Solano counties, held at the Meadow Country Club, at which Marin County was host. The very interesting address of President John W. Cline of the A.M.A. was instructive and heartening to all those present. The meeting was conducted very ably by the president of the Marin County Medical Society, Dr. Warren L. Bostick. There appeared to be in excess of a hundred persons present.

The visits of the President-elect, Dr. Lewis Alesen (California Medical Association) of Los Angeles to Solano, Napa, Humboldt, Mendocino-Lake, and Sonoma counties were very inspiring meetings. Dr. Alesen was accompanied by Ed Clancy and Glenn Gillette of the public relations staff of the C.M.A., and Mr. Ben Read, Executive Secretary of the Public Health League of California. In most instances, the meetings were well attended. John Hunton, Executive Secretary, attended the Vallejo meeting and was very helpful. It is the opinion of your Councilor that these meetings with state officers are of interest to the local groups and are advantageous to the state Association as a whole. We suggest that members of the Auxiliary be invited to attend all such gatherings. We heard many compliments from the ladies concerning the remarks of President-elect Alesen, and we feel that the work of the Auxiliary will be more effective if their members are given an opportunity to come in more intimate contact with state officials more frequently.

In December, Napa County Medical Society gave a wonderful testimonial dinner for Dr. D. H. Murray, Legislative Chairman of the C.M.A. and Chairman of the Board of Trustees of the A.M.A. Many prominent guests were present, representing all segments of community life. Dr. Cline expressed the delight which was his in being able to be present to honor Dr. Murray and to express the thinking and the policies of the A.M.A., in which Dr. Murray plays such a prominent part. Dr. Sidney J. Shipman, Chairman of the Council, and Dr. Francis Scott Smyth, Dean of the University of California School of Medicine, San Francisco, and Dr. Anthony Diepenbrock and Dr. Robertson Ward contributed to the pleasure of the evening and were aided by such persons as State Senator Nathan Coombs of Napa County and Assemblyman Ernest Crowley of Fairfield. Dr. Lawrence Welti of Napa, in the absence of the mayor, presented the address of welcome and the chairman of the Board of Supervisors, Mr. Eddington, responded for the County of Napa. Mr. Ben Corlett, past president of the California Bankers Association and now vice-president of the American Trust Company of San Francisco, gave an especially interesting and talented talk on a "Free Society vs. Socialism" which I am sure every man enjoyed.

Ben was formerly of Napa, and later on, state commissioner of banks of California. There were representatives of the staff of the State Hospitals at Imola and the Veterans Home of Yountville. This meeting was ably arranged for by Dr. George Dawson and Dr. Robert Northrup, secretary of the Napa County Medical Society, who presented Dr. Murray with a set of beautiful matched pipes, in the name of the society. Dr. Mike Boothe of St. Helena read many telegrams and letters of regret from persons unable to attend the dinner. The remarks of Dr. Murray, when called upon, were typically "Murrayian" and enjoyed by all who were present. The group was proud to have John Hunton, Ben Read, Ed Clancy, and Glenn Gillette present to make the occasion a most enjoyable event. We still have one visitation to make in February 1952, to the Marin County Medical Society, when our tour of duty will have been completed.

Respectfully submitted,

JOHN W. GREEN, *Councilor,*
Tenth District

ELEVENTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba Counties

To the President and the House of Delegates:

The proposed public relations program with emphasis on activities at the local level has been explained by the C.M.A. representatives to the doctors of the 20 counties comprising this district. It is apparent that if this program is to fulfill its ultimate possibilities, considerable individualization to meet local conditions will be necessary. It is also obvious that its ultimate success will depend on the energy, personality, and ability of those entrusted with its administration. Inasmuch as the activities of these C.M.A. public relations representatives should provide much closer liaison between the county societies and the state association, the present policy of annual visits by C.M.A. officers might well be reviewed. These visits are unquestionably valuable, and appreciated, but they are time-consuming and expensive. It would seem doubtful whether they are actually necessary and desirable every year.

Six new hospitals have been built, or are under construction in this area, but several of the larger cities are still short of hospital beds. There are no shortages of doctors, and new men are constantly coming to this section of the state.

Respectfully submitted,

WAYNE POLLOCK, *Councilor,*
Eleventh District

REPORTS OF COUNCILORS-AT-LARGE

NOTE: The report of Dr. Sidney J. Shipman as Councilor-at-Large is made a part of his report as Chairman of the Council.

To the President and the House of Delegates:

I have attended and participated in all Council meetings of the past year and of the several committees assigned.

Respectfully submitted,

C. V. THOMPSON, *Councilor-at-Large*

To the President and the House of Delegates:

A number of bills were introduced by the Board of Medical Examiners in collaboration with the California Medical Association, with the result that the practice of medicine is now more clearly defined, and the requirements for examination have been completely modernized, leaving out such terms as "materia medica," etc.

A large amount of time was spent with the psychologists, who are anxious to have official recognition. It is to be hoped that legislation eventually will be worked out so this group will be *registered* with the Board of Medical Examiners, rather than *licensed* by a board of their own.

Respectfully submitted,

WILBUR BAILEY, *Councilor-at-Large, Member, State Board of Medical Examiners*

To the President and the House of Delegates:

As Councilor-at-Large I have attended the meetings of the Council of the California Medical Association and have taken part in the discussions and decisions of the Council. I have also carried out committee and other assignments.

In addition, as director of the San Francisco County Medical Society, I have endeavored to correlate state and county organizations.

Respectfully submitted,

IVAN C. HERON, *Councilor-at-Large*

To the President and the House of Delegates:

During the past year I have attended the Council meetings and have visited, along with the C.M.A. officers, county medical societies in Southern California. The matter of C.P.S. and prepaid health insurance in general, along with other vital matters have been studied, discussed and then voted upon in the best judgment of the Council. In the sudden death of Dr. John Ball, Councilor from the Second District, we have lost a fine friend and Councilor.

The published reports and proceedings of the meetings of the Council attest to the serious thought given to the affairs of the Association by all of the elected officers and employees.

Respectfully submitted,

ARTHUR E. VARDEN, *Councilor-at-Large*

To the President and the House of Delegates:

Having been in regular attendance at the Council meetings for the year 1951, I can assure the membership that the work done and the accomplishments achieved are in line with the high standards set forth by the organization which we represent.

The place of medicine in state and national affairs is an enviable one, and we carry on in 1952 with the hopes of a real victory.

BEN FREES, *Councilor-at-Large*

REPORTS OF COMITTEES

EXECUTIVE COMMITTEE

To the President and the House of Delegates:

The Executive Committee has held meetings between Council meetings and such special meetings as were necessary to act upon matters which needed prompt attention. The minutes of the Executive Committee have been presented to the Council for approval and have been subsequently published in CALIFORNIA MEDICINE.

The Council has delegated to the Executive Committee the duty of reviewing the public relations program and authorizing necessary expenditures to the carrying out of that program. All actions are subject to confirmation by the Council.

All members of the Executive Committee have been most attentive and cooperative in their work.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

To the President and the House of Delegates:

There have been no meetings of the committee during the past year and no communications have reached me as chairman of the committee from the California State Nurses Association, or from any other society or technical group. No specific action by the committee has been requested by the Council.

Respectfully submitted,

ROBERT A. SCARBOROUGH, *Chairman*

AUDITING COMMITTEE

To the President and the House of Delegates:

The budget for the fiscal year 1951-1952 was presented.

The budget for the coming year is now under study for presentation at the annual meeting. Expenditure items are reviewed month by month.

An audit made by our certified public accounting firm found all records to be in good order. Recommendations as to minor business procedures have been placed in effect.

Respectfully submitted,

DONALD D. LUM, *Chairman*

COMMITTEE ON HISTORY AND OBITUARIES

To the President and the House of Delegates:

The continuing growth of our state association brings with it the inevitable increase in the number of our members who have passed on to their final reward. During the past year our secretary has listed 125 deaths, by far the largest toll of any one year.

It is impossible for any state committee to properly note the many distinguished achievements of these members, and yet a record should be maintained in our central files which would show more than a mere date of death and year of graduation and license to practice. There should be an active committee in each county component whose privilege (not duty) is to compile and send in to the state secretary a reasonably complete biography.

In San Joaquin County, for example, for the last 35 years, a time has been reserved at the first regular meeting following the death of a member at which time the chairman of the local committee on History and Obituary gives a carefully prepared, accurate tribute to the departed member. This record contains not only statistical data of place and date of birth, early education, medical school, postgraduate hospital or special training, places of practices, contributions to literature or teaching positions, hospital and society affiliations, but also lists hobbies, community service rendered, marital history and any personal outstanding characteristics of the individual.

This custom has through the years, in this county society, been well received by the members and has greatly impressed any visitors attending these meetings. A copy of the

remarks sent to the family also is deeply appreciated. We fully realized that the larger county units could not give the time each month at their general meetings but either through an active committee or the paid office staff could gather the data and see that it reached headquarters. With the exception of a few of the very large county units we urged the adoption of the method followed in San Joaquin County.

The list of 125 members contains the names of members nationally and internationally known for their brilliant contributions to our professional knowledge, and even the most humble will leave patients, friends and family who feel a keen sense of personal loss. May we, who carry on, maintain the high standards of our profession, as they would have us do.

Respectfully submitted,

DEWEY R. POWELL, *Chairman*

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

To the President and the House of Delegates:

The Committee on Hospitals, Dispensaries and Clinics held a meeting on December 1, 1951, to discuss matters which had been placed before it for consideration and report. Since this committee is of an advisory nature only, reports will be made to the Council after the completion of our studies.

Respectfully submitted,

JOHN B. HAMILTON, *Chairman*

COMMITTEE ON INDUSTRIAL PRACTICE

To the President and the House of Delegates:

During the year 1951 no problems have been referred to the Committee on Industrial Practice by the Council or the House of Delegates. No meetings of the committee were held during the year, no business was transacted and there is no unfinished business.

Respectfully submitted,

JEROME W. SHILLING, *Chairman*

COMMITTEE ON MEDICAL DEFENSE

To the President and the House of Delegates:

The Committee on Medical Defense has had no meeting during the past year, and no communication or business has been referred to the committee for action.

Respectfully submitted,

H. CLIFFORD LOOS, *Chairman*

COMMITTEE ON MEDICAL ECONOMICS

To the President and the House of Delegates:

The Committee on Medical Economics wishes to submit the following report for its activities of the past year:

The projection of the Dichter Report, entitled "Doctor and Patient," by Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, was published in essay form and sent to all the members of the California Medical Association.

The "Doctor and Patient" has received wide recognition. As a consequence, Dr. Dichter was invited to appear on the program of the National Public Relations Committee of the A.M.A. He outlined work done in California and set the stage for national consideration. The Dichter report projection has received wide publicity. It was the subject of a lead article in the Journal of the Academy of General Practice. It also was given similar treatment by the periodical *Medical Economics.* Various medical societies throughout the nation have given recognition.

It is hoped the work started three years ago will be continued and expanded in the future with the California Medical Association continuing its role of leadership.

Respectfully submitted,

ARTHUR A. KIRCHNER, *Chairman*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

To the President and the House of Delegates:

A meeting of the Committee on Medical Education of the California Medical Association was held on January 10, 1952, at the St. Francis Hotel, San Francisco. In attendance at the meeting were: Dr. Loren Chandler, Dr. Stafford Warren, Dr. W. E. Macpherson, Dr. Dwight Murray, Dr. H. Gordon MacLean, Mr. John Hunton, Mr. Howard Hassard, Mr. Ed H. Clancy, and Mr. Robert L. Thomas. Absent were: Dr. Laurence Montgomery and Dr. Lewis T. Bullock.

The subject of a proposal to amend the Business and Professional Code so as to control the influx of foreign students in the field of medicine was discussed. It was emphasized that the proposal was designed so as to meet the desirability of aiding medical education in foreign countries without encouraging permanent *licensure* or residence of graduates of foreign schools, many of which need help because they are (by comparison) substandard. Attention was drawn to the increasing number of students in all fields who are brought to this country with the intent of good international relations by Fullbright, Smith-Mundt and Foundation subsidies through the Conference of Resident Councils of the International Education Exchange, et al. The need for cooperative clarification regarding the American system of medicine and medical licensure has been recognized by the Association of American Medical Colleges, the Council on Medical Education and Hospitals of the American Medical Association and the Association of State Boards of Licensure.

1. The committee approved the intent of the legislation and recommended that the proposed amendment (see below), subject to more definitive legal references and additions, be submitted to the Council of the California Medical Association and the Board of Medical Examiners.

PROPOSED AMENDMENT

As a *preamble* to the proposed amendment to Section 2147.5 of California legislation relating to medicine and surgery, the following may be considered:

"An amendment is desired which will assist members of teaching staffs elsewhere, who seek to further their knowledge in the newer techniques of medical education, and thus improve the standards of medical education in other countries."

Proposed amendment (now being considered by C.M.A. counsel):

"Physicians with visitors' visas, seeking postgraduate study in an approved medical school of California either as a fellow, assistant instructor, or exchange professor; after proper application and approval by the State Board of Medical Examiners and appointment of such an applicant by the Dean of the approved medical school may obtain a permit to participate in the activities of the department to which he is appointed under the direction of the chairman of that department for the duration of his appointment by the university.

"This permit shall not exceed one year, and must be renewed semi-annually. This work shall in no case be accepted as a substitute for the year's internship required in examination for licensure."

At a meeting of the Advisory Board, Dr. Ed Bruck expects to have a statement on any changes which are required in the proposed amendment.

2. The problem regarding the relationship of osteopaths to postgraduate, postdoctorate educational programs, particularly those of the State University Extension Division, was presented. The committee recommended that this matter be referred to the California Medical Association for long-range policy analysis and action.

3. The Stanford and University of California Schools of Medicine in San Francisco presented the situation created by the request of the Western Medical College (drugless practitioners) that the San Francisco Supervisors permit the use of the San Francisco Hospital for the students of the Western College of Medicine.

4. The committee requested that the attention of the Association of American Medical Colleges, the Council on Education of the American Medical Association, and the Association of State Boards of Licensure be called to the increasing number of American students attending foreign medical schools. It was suggested that academic colleges be informed regarding the difficulties of licensure, etc., for such students, so that advisors and pre-professional counsel might dissuade and deter, if possible, this ill-advised and growing program.

Respectfully submitted,

FRANCIS SCOTT SMYTH, *Chairman*

COMMITTEE ON MILITARY AFFAIRS AND CIVIL DEFENSE

To the President and the House of Delegates:

At the 1951 Annual Session, House of Delegates of the California Medical Association, the Constitution was amended to provide for a new standing committee. This new committee to be known as the Committee on Military Affairs and Civil Defense. This new committee replaced the Emergency Medical Services Committee and in addition provided for Military Affairs.

The members appointed to this committee are as follows: Frank F. Schade, Los Angeles (1952); William L. Bender, San Francisco (1953); Justin J. Stein (chairman), Los Angeles (1954).

CIVIL DEFENSE

The California Medical Association has: (1) Participated in atomic energy training courses regarding medical aspects of atomic warfare; (2) kept abreast of civil defense activities in the state in meetings with the Citizens Medical Advisory Committee and with the California Disaster Council; (3) sent representatives to medical civil defense conferences sponsored by the Council on National Emergency Medical Service of the American Medical Association; (4) correlated its activities with those of dental, nursing, veterinarian and other such organizations through memberships in the Citizens Medical Advisory Committee of the California Disaster Council; (5) encouraged the presentation of lectures on Civil Defense at medical meetings; (6) helped plan civil defense exhibits (soon to be available) for use at Civil Defense meetings; (7) helped in the planning and organization of a blood and blood derivatives program (the California Medical Association has been very active in this phase of civil defense); (8) taken part in radiological safety advisory committee planning; (9) arranged to conduct refresher courses for county medical civil defense committees; (10) assisted in the preparation of the following manuals:

Manual for Emergency Field Treatment of Casualties. This manual outlines standardized treatment procedures for use in the field. It will be 4 x 6 inches in size and circulated to all interested groups.

Hospital Disaster Plan Guide for Existing Hospitals. Recommendations for the organization of hospital facilities and personnel are given in detail.

Plan for Operation of a First Aid Station.

Hospital Plan of Operation for Improvised Hospitals.

Fundamental points regarding the medical aspects of Civil Defense in California are presented in an article on this subject in the January 1952 issue of CALIFORNIA MEDICINE.

Submitted by JUSTIN J. STEIN

* * * * *

MILITARY AFFAIRS, NORTHERN CALIFORNIA

This is to summarize the activities of Northern California Advisory Committees for the last six months of 1951 and to forecast the events of the coming months insofar as that is possible.

ADVISORY TO THE SELECTIVE SERVICE SYSTEM:

Since deferments of Priorities 1 and 2 registrants have been limited, usually to six months, review of these cases at the end of the deferment-period has been a continuing process. You will note from Tables I and II that occupational deferment of physicians in Classification II-A, with which the advisory half of the program has been concerned chiefly to date, has decreased from 18.9 per cent for the nation and 20.7 per cent for California, up to May 31, 1951, to 6.4 per cent for Northern California, as of December 31, 1951. Current figures for the other areas are not yet available to us but may be assumed to show a similar proportion of occupational deferments. The sharp decrease may be attributed largely to the availability of hospital interns and residents at the end of the year of training for which they had been deferred, June 30, 1951. Such trainees still account for most of the medical deferees and the percentage may be expected to decrease further at the end of the current academic year June 30, 1952.

The tables give full details. Table I reports on physicians while II includes dentists as well.

TABLE I

Number of Priority 1 Physicians by Classification for Continental U. S. and California as of May 31, 1951

	Continental U. S.	California	Per Cent of Continental U. S.
Total—living registered	10,287	860	8.4
Total—classified	10,246	856	8.4
I-A and I-A-O examined and accepted	1,804	101	5.6
Total—other classification	8,442	755	8.9
Not examined	790	111	14.1
Postponed	37	-----	----
IV-E	23	1	4.3
I-C-Enlisted	1,591	105	6.6
I-C-Discharged	1	-----	----
I-D	2,182	197	9.0
II-A	1,940	178	9.2
III-A	122	9	7.4
IV-A	42	7	16.7
IV-F	1,709	146	8.5
V-A	2	-----	----
Disqualified—physical and mental	3	-----	----
Disqualified—morals	.....	-----	----

It is estimated that Medical Priority 1 will have been exhausted by April 1952, when Priority 2 will become subject to induction. Since there have been only 76 registrants in 2, compared with 430 in 1, Priority 3 should become vulnerable much sooner. So far there have been no official estimates of the date. Priorities 3 and 4 have not yet been

classified. The small number, 28, of Priority 1 acceptable (Table II, Item 3) simply indicates that these few have not yet received a commission, compared with those in I-C and I-D (Items 7 and 14), plus a surprising proportion of IV-F classifications. As you know, every effort has been made to stimulate application for a commission in lieu of induction; we have heard of only two actual inductees in the nation.

TABLE II

Selective Service System—Summary of Classification Special Registration No. 1—California—Northern Area

Classifications	Medical Pr. 1	Medical Pr. 2	Dental Pr. 1	Dental Pr. 2
1. Total living special registrants	432	76	162	9
2. Total classified special registrants	430	76	162	9
3. I-A and I-A-O examined and acceptable	28	25	11	1
4. I-A and I-A-O not examined	10	3	2	....
5. I-A Postponed	....	....	....	....
6. I-C (Inducted)	....	....	....	....
7. I-C (Enlisted or commissioned and on extended active duty)	138	2	63	2
8. I-C (Discharged)	....	....	....	....
9. I-C (Reserve)	....	....	....	....
10. I-O Examined and accepted	....	....	....	....
11. I-O Not examined	1	....	....	....
12. I-W	....	....	....	....
13. I-W (Released)	....	....	....	....
14. I-D (Reservist)	111	10	52	3
15. II-A (Occupational deferment)	28	18	7	....
16. III-A	5	1	4	....
17. IV-A	2	....	....	....
18. IV-D	....	1	....	....
19. IV-F (Physically, mentally or morally unfit)	107	16	23	3
20. V-A	....	....	....	....
21. Total canceled	11	2	....	....

While much of the activity, as far as Advisory Committees are concerned, has been among the medical registrants, you will note a proportionate number of dental registrants hold commissions. Veterinary registrants are in less military demand up to the present time but recently we note some increase.

Of interest to all three professions is the recent graduate who has had no active duty and therefore becomes a special registrant in Priority 3. However, many are under the age of 26 and therefore were regular registrants before graduating. These men are considered doubly liable for active military duty and advised to apply for a commission with the request for immediate active duty, after an internship in the case of a medical registrant. The number of such individuals is expected to increase annually.

Another important consideration is the return of medical, dental and veterinary officers to civilian life after the allotted period of service has been completed. Much is expected of this rotation to provide replacements particularly for hospital residents, teachers and in isolated communities. The Korean war started about the first of July 1950, reserve officers were being called up soon afterward and are expected to start returning in appreciable numbers by summer. The following is the current schedule of release:

The Department of the Navy is using the following policy in regard to release from service of physicians and dentists (former registrants and reservists):

Priority I	24 months
Priority II	12-24 months
Priority III	24 months
Priority IV:	
(12 months during World War II)	12-17 months
(Less than 12 months during World War II)	12-24 months

The Department of the Army is operating, at present, on the following program:

Any physician or dentist who served 12 months during World War II becomes eligible for release after 17 months of current service, except those called in Organized Reserve Units, who will serve the full 24 months.

The Department of the Air Force is operating, at present, on the following program:

Any physician, dentist or veterinarian may request release after 21 months of service. If he was in Priority I or II, the 21 months must be during the present term of service.

Several requests for deferment because of research or teaching have been difficult of solution by both local and state committees, sometimes with a difference of opinion. Some have been referred to the national committee for recommendation.

As a period of deferment ends, each case is to be reviewed for availability of the registrant for active military duty; he is reclassified in I-A unless the advisory committees find cause for granting another period of deferment (up to six months), and such recommendation is accepted by the local draft board. Usually the request for review comes to the Northern California Advisory Committee office and the Forms A are sent to the local Advisory Committees for completion. If the draft board makes the request directly to the local committee, procedure may be initiated there. In either case, completed forms are returned to the Northern California Advisory Committee office for review and transmittal to the Selective Service System. If the local advisory committees wish to know the result of a recommendation, or when a deferment period ends, we will be glad to get this information to them on request.

ADVISORY TO THE ARMED FORCES

This function of the advisory committees proceeds as outlined in a letter of instruction of May 10, 1951. A reserve officer recalled to active duty by any of the three services may request delay in activation, in which event the service refers the case to the advisory committees for recommendation and we follow the same procedure as with a Selective Service registrant's request for deferment.

In addition, the Health Resources Advisory Committee (same personnel as our National Advisory Committee) on several occasions has sent lists of Naval Reserve dentists or physicians for our opinion on their essentiality in civilian practice or their availability for military duty. These names are sent from this office to the local advisory committee concerned for investigation and recommendation.

Submitted by WILLIAM L. BENDER

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MILITARY AFFAIRS, SOUTHERN CALIFORNIA

1. Deferments of Priority I and Priority II special registrants have been limited, usually to six months or less. At the end of the deferment period, individual cases are again reviewed.

2. It has been estimated that Medical Priority I will be exhausted by April of 1952, at which time Priority II special registrants will become vulnerable. As there is a total of only 86 Priority II medical registrants as compared with an original total of over 400 in Priority I, Priority III will become vulnerable in a much shorter period of time than estimated primarily. However, no official estimates of this date have been made.

3. The recent graduate who has had no active duty and therefore becomes a special registrant in Priority III has a dual liability for military service if he is under 26 years of age (Doctor Draft and the Universal Military Training and Service Act, as amended). If he has been deferred by reason of internship, student classification, etc., on or after June 19, 1951, his liability is extended to 35 years of age.

In regard to these individuals, local boards are being advised to defer only until the completion of the first year of internship, at which time the registrant is advised to apply for a *commission* and *immediate active duty* so that the period of obligated military duty may be completed at a convenient time. If they do not apply for active duty simultaneously they will become Priority II reserve officers which *will not* relieve them of their liability under the general provisions of the Universal Military Training Act until the advent of their thirty-fifth birthday.

4. Citizens of Canada, and some other countries which do not have special treaty arrangements, who enter this country as aliens on a visa to accept employment such as a residency and who hold an M.D. degree, must register as special registrants within five days of the time of their entry into this country. Such aliens who have not attained their twenty-sixth birthday must also register as regular registrants within six months from the date of entry. After registration and unless otherwise entitled to a deferment, they will be liable for induction into the armed forces on the same basis as citizens of the United States. (Most of them will fall into Priority III as special registrants.)

5. When requesting a second delay of reserve officer, we have been advised to ask for resignation and hold individual as a special registrant under Selective Service.

6. The Health Resources Advisory Committee periodically sends lists of medical, dental and veterinarian Reservists for our opinion on essentiality in civilian practice or their availability for military duty. These names are sent from this office to the local county Advisory Committees for investigation. Recommendations are returned to us for review and transmittal to the Health Resources Advisory Committee, Washington, D.C., thence to the Service making the inquiry.

A reserve officer recalled to active duty by any of the three services may request delay in activation, in which event the service refers the case to the State Advisory Committee for recommendation. However, former Priority I and II registrants who were investigated and classified I-A by their local selective service board prior to accepting a commission, are assumed still available for active duty.

7. The Korean War started about the first of July 1950, and therefore many reserve officers who were called up soon afterward are expected to be released from service shortly and will be returning in appreciable numbers by summer. Much is expected of this rotation to provide replacements particularly for hospital residents and teachers, and in isolated communities.

(For the current schedule of release, see Northern California report on preceding page.)

TABLE III

First Priority (Medical) 1951—Showing quarterly the number within each classification.

	Mar.	June	Sept.	Dec.	Percentage of Reduction or Increase
*I-A	146	87	73	57	Reduced 62%
*II-A	97	124	83	69	Reduced 29%
*IV-F ..	22	49	79	111	Increased 80%
*I-D	49	81	86	91	Increased 46%
*I-C	12	13	81	117	Increased 90%

Total count as of December 31, 1951.....454
(Including 8 classified I-AO—1 classified IV-A)

* I-A: Examined and Acceptable
II-A: Occupational Deferment
IV-F: Physically Unfit
I-D: Reserve Commissions
I-C: Active Duty

Our files show that as of January 15, 1952: 52 doctors are classified II-A. Seventeen of these II-A classifications expire on or before January 31, 1952. Eight of these II-A classifications expire on or before April 30, 1952. All but a very limited number will expire June 30, 1952.

8. The National Advisory Committee has authorized the appointment to State Committees of a representative of the nursing profession. The Southern California Advisory Committee welcomes Mrs. Helen Halverson, R.N., Los Angeles County Health Department, as our new member.

9. Included in this report is a chart showing classifications of Priority I Medical Registrants of Southern California for the year 1951 (see Table III).

Submitted by JOHN C. RUDDOCK

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Respectfully submitted,

JUSTIN J. STEIN, *Chairman,*
Committee on Military Affairs and Civil Defense

PHYSICIANS' BENEVOLENCE COMMITTEE

To the President and the House of Delegates:

The Physicians' Benevolence Committee has carried on its regular activities in the past year. A complete financial report is shown below; this is self-explanatory and shows that the Benevolence Fund ended the 1951 calendar year with a surplus of $42,642.92, up $4,438.89 from a year earlier. Surplus funds are invested in U. S. Treasury bonds.

BENEVOLENCE FUND

RECEIPTS AND EXPENDITURES
January 1951 through December 1951

January 1, 1951, Balance:		
Cash		$11,205.03
U. S. Treasury Bonds		27,000.00
		$38,205.03
Receipts:		
Interest on U. S. Treasury Bonds	$ 675.00	
Contribution—Butte-Glenn County Woman's Auxiliary	50.00	
Contribution—Woman's Auxiliary, C.M.A.	2,648.13	
Contribution—C.M.A.	10,628.75	
		14,001.88
		$52,206.91
Expenditures:		
Benefits paid		9,562.99
		$42,643.92
December 31, 1951, Balance		
Cash	$15,643.92	
U. S. Treasury Bonds	27,000.00	
	$42,643.92	

During the past year the committee has been able to place one of its aid recipients in a veterans' home, where he is assured of constant care and medical treatment. Another recipient is gradually recovering from a long illness and should be entirely independent of outside assistance within a short while.

Aid has been given to five individual physicians or their families during 1951. At the same time, regular contributions have been made to the Los Angeles County Physicians' Aid Association, which has used these funds as a part of the benevolence program covering some forty recipients in that county. Regular reports are filed with the C.M.A. committee on the Los Angeles activities.

The committee wishes to express its heartfelt thanks to the Woman's Auxiliary for its continued support and interest. The Auxiliary has not only entered into special projects to raise funds for the Benevolence Fund but has been of extreme help in locating and social servicing needy cases.

The chairman wishes also to express his extreme thanks to the other committee members, Dr. Elizabeth Mason Hohl of Los Angeles and Dr. John W. Sherrick of Oakland, for their constant and ever-ready cooperation. In every instance both of them have responded immediately to any call for action.

Respectfully submitted,

AXCEL E. ANDERSON, *Chairman*

COMMITTEE ON POSTGRADUATE ACTIVITIES

To the President and the House of Delegates:

During the year of 1951 your Postgraduate Committee has continued the program already under way since 1950. At the convention of the C.M.A. the resignation of Dr. John C. Ruddock, as chairman of the standing committee on Postgraduate Activities was accepted. To fill this vacancy on the committee, Dr. John D. Ball of Santa Ana was appointed. It is with extreme regret that your committee reports the death of this valued member of the committee. Dr. Edward C. Rosenow, Jr., was appointed chairman. Dr. Andrews is a continuing member. Dr. C. A. Broaddus of Stockton was continued as director.

Since May, the chairman has had conferences with the director on numerous occasions and with other members of the committee individually. A meeting is scheduled for January for the whole committee.

The Regional Medical and Surgical Institutes have been extremely successful, and have been continued. In 1951 these were held in the following localities: The Southern Counties met at Riverside, January 25 and 26, with a registration of 146. The Sacramento Valley counties met at Sacramento, February 8 and 9, with a registration of 198. The North Coast Counties Institute met at Santa Rosa, March 8 and 9, with a registration of 88. The San Joaquin Valley counties met at Fresno, October 4 and 5, with a registration of 203. The West Coast Counties met at Santa Barbara, October 25 and 26, with a registration of 96.

In addition to these registrations there were from six to 15 interns and residents in attendance at each of these Institutes and a considerable number of registered and student nurses. Regional Institutes have been arranged for the opening months of 1952 to be held at San Bernardino, January 17 and 18, and at Santa Rosa, February 14 and 15, with another Institute in the Sacramento Valley counties at Sacramento, April 3 and 4.

In addition, the Postgraduate Committee has arranged to have single speakers at the following county medical society meetings: Merced, Stanislaus, Imperial, San Luis Obispo, Placer-Nevada, Tulare, Napa, Kings, Riverside, Kern and Yuba-Sutter. At these single lectures there was a total of 550 doctors in attendance.

Your director has also helped in the conduct of the Stockton Postgraduate Study Club, which arranged for a series of eight lectures during the months of September, October and November. The total registration for this program was 147, with an additional 22 interns, residents and premedical students.

The program for each Institute has been under the direct cooperation of an individual medical school, and the programs have been very well accepted. The Institutes have been classified by the American Academy of General Practice as acceptable to fulfill postgraduate requirements of general practitioners. Suitable attendance reports are available to general practitioners who wish credit for their Academy of General Practice requirements.

Another meeting with the Advisory Committee consisting of representatives from the medical schools as well as from the state society is planned for the early months of 1952. Your committee feels that the program initiated is of wide general interest and should be continued. Therefore, your committee requests the House of Delegates that the Council of the C.M.A. be directed to continue the allocation of funds for the support of this committee in making possible postgraduate opportunities for its members.

The California Medical Association may indeed feel proud of its part in fulfilling a real service to its membership by making this high-caliber postgraduate opportunity available to them.

Respectfully submitted,

EDWARD C. ROSENOW, JR., *Chairman*

See financial report below.

Financial Statement

Stockton Office Expense:		
Director's salary	$6,000.00	
Secretary	1,770.00	
Special help in office	85.00	
Miscellaneous supplies	87.87	
Postage—envelopes	464.93	
Stationery	10.57	
Office rent	600.00	
Telephone rental and tolls	128.02	
Printing (incl. stationery)	886.49	
Plastic badge cases	62.33	
Travel Expense:		
Director and Secretary—		
Hotel	385.28	
Auto and railroad	477.27	
Meals	299.19	
Total		$11,256.95
Speakers—5 Institutes—13 individual rural lectures:		
Honoraria	$2,300.00	
Travel expense	1,129.94	
		$ 3,429.94
Regional Committee's expense (travel and hotel). (This is for the meeting held in Los Angeles when representatives from each of five Regional Committees, each of five medical schools, and the members of the Standing Committee met for consultation; also covers expense of a meeting with the Advisory Committee in Los Angeles in May 1951.) (Balance includes luncheon and dinner meetings held with each Regional Committee in preparation for Institute programs.)		
Meals and travel expense		918.82
Exhibit at Annual Meeting—		
Labor, material and trucking		554.21
Refreshments during Institutes		370.00
Expense—Director to A.M.A. Convention, Atlantic City		451.72
Grand Total		$16,981.64
Income from Institutes—		
Riverside, Jan. 1951	$ 700.00	
Sacramento, Feb. 1951	990.00	
Santa Rosa, March 1951	440.00	
Fresno, Oct. 1951	1,015.00	
Santa Barbara, Oct. 1951	480.00	3,625.00
Cost to C.M.A., 1951:		
5 Institutes; 13 County Meetings		$13,356.64
Budget:		
First six months	6,000.00	
Second six months	7,500.00	
		$13,500.00

COMMITTEE ON PUBLIC RELATIONS

To the President and the House of Delegates:

As announced in the November 1951 issue of CALIFORNIA MEDICINE, the Council has established the new Public Relations Department and approved the grass roots public relations program presented by the Advisory Planning Committee.

The plan stresses two major points, "the provision of 'round the clock medical services regardless of ability to

pay, through the full use of existing local facilities, and the establishment and activation of Public Service Committees (Fee Committees or Ethics Committees) within County Medical Societies where patients may have a hearing and an answer to real or fancied complaints against a member of the profession."

Since the formation of the new department, public relations representatives have appeared with officers of C.M.A. and explained the plan to the members of the various County Societies. The program has been well received and it is highly encouraging to note the number of societies which have already—and voluntarily—inaugurated all or parts of the plan to better the relations of the profession with the public.

Routinely, the department has been of assistance in the publicity phases of C.M.A.'s activities, the Postgraduate Program and the Blood Bank Commission. Various services have, upon the invitation of society officers, been performed at the county level.

As announced by the Council, the new department is particularly designed to be of assistance to County Societies not having executive secretaries.

In Northern California, Mr. Glenn W. Gillette is "at the service" of northern societies. Mr. J. L. Pettis performs in a similar capacity in the south.

Respectfully submitted,

ED CLANCY, *Director*

COMMITTEE ON SCIENTIFIC WORK

To the President and the House of Delegates:

The Committee on Scientific Work held two meetings during the year as well as meeting with the section officers twice.

The 1952 Scientific Program will again be changed from previous meetings, and it is hoped that eventually the best schedule will be arrived at.

The first and opening meeting of the Scientific Program will be held on the afternoon of the first day following the meeting of the House of Delegates. In this way it is hoped that more will attend since the principal guest speakers appear at this time.

The tradition of a free afternoon to permit members to visit the scientific and technical exhibits and to provide time for the Golfing Association to meet was broken to allow the Public Health Section to meet. In the future more sections will probably need this time for meetings. The Committee on Local Arrangements was reactivated last year by the Council and the former's work was so excellent that it was felt advisable to continue with an active committee. In time this committee may become extremely useful to the Association, particularly as the meetings become larger.

The policy of not sanctioning meetings of other organizations during the state meetings has been maintained, but again not without difficulties, particularly from one or two organizations who feel that they should be permitted to meet at this same time.

Mr. Robert Edwards will be in charge of press coverage and there will be a "Meet the Press" luncheon on Saturday, April 26. At this time the press will be given an opportunity to review all papers with summaries written for laymen available for them.

Section executives last year were present at section meetings and they facilitated greatly the respective programs. They will again be called upon to provide the smooth inner workings of section meetings.

Respectfully submitted,

ALBERT C. DANIELS, *Chairman*

ANNUAL REPORT OF THE CANCER COMMISSION

To the President and the House of Delegates:

The Cancer Commission has functioned actively during the past year to continue and expand a program of service to the people of California in achievement of early diagnosis and effective treatment of cancer. To this purpose, close cooperation has been maintained with the California Division of the American Cancer Society, with members of the commission continuing to take an active part on the board of directors, executive committee, and all other committees. The commission wishes to acknowledge the great assistance, financial and otherwise, rendered by the California Division of the American Cancer Society. It also wishes to commend the Medical Director of the Cancer Commission, Dr. Franklyn C. Hill, for his conscientious and efficient services.

Activities of the commission, accomplished and continuing, include the following:

1. Twenty-three cancer conferences have been held in 23 county medical societies, with a total attendance of 1,614 persons. This attendance comprised almost 55 per cent of the membership of the county medical societies concerned. The expenses of this program, totaling $3,725, were borne by the California Division of the American Cancer Society. A program for cancer conferences in 1952, in approximately 24 counties, is well under way.

2. Two refresher courses for the Southern California Dental Association have been scheduled and programs arranged.

3. A midwinter conference of Tumor Pathology was held in Los Angeles in December. The annual preconvention conferences in Tumor Pathology and in Radiology will be held immediately preceding the April meeting of the California Medical Association.

4. Fifty Consultative Tumor Boards, previously approved by the Cancer Commission, have been inspected during the year. Four more boards, having met the minimum requirements standards of the commission, have been approved.

5. With the approval of the Council, the Los Angeles County Tumor Registry has become the Tumor Tissue Registry, Cancer Commission, California Medical Association. This registry is developing rapidly, and should afford invaluable service to the members of the California Medical Association. Substantial financial support, originally aided by Federal funds, is now contributed by the American Cancer Society. Among the objectives of this registry are the following: (a) to serve as a consultative and advisory group to recognized pathologists whenever such service may aid in histologic diagnosis of neoplastic disease; (b) to establish a museum of tumors; (c) to establish a registry of tumors and to make material available for study by the pathologists of the state and at Cancer Commission conferences; (d) to prepare and distribute microscopic-study loan sets of tumors.

6. Arrangements have been made to renew, for a second year, distribution of the bimonthly journal *CA*, published by the American Cancer Society, to nearly five thousand physicians in general practice in the state, the cost to be shared equally by the Cancer Commission and the California Division of the American Cancer Society. The mailing list for this journal was revised after conducting a mail poll which disclosed that 7 per cent of recipients did not desire their subscription renewed. Any member of the California Medical Association may be placed on the mailing list by written request to the Cancer Commission.

7. The monograph "Cancer of the Esophagus and the Stomach" by Owen H. Wangensteen, M.D., has been dis-

tributed to 14,134 California physicians through the courtesy of the American Cancer Society. This is the third of a series of brochures on cancer in specific sites.

8. A new film, "Breast Self-Examination," produced and distributed by the American Cancer Society and approved by the Cancer Commission, has been shown during the year 1,951 times to a total lay audience of 72,379. Another film, "Uterine Cancer, the Problem of Early Diagnosis," should be available for use in the program of professional education in the very near future.

9. The Cancer Commission is deeply interested in a program to make *every private physician's office a center for detection of cancer.* A positive program of lay education, conducted by the American Cancer Society, has placed an increased responsibility on the medical profession in the performance of examinations for signs of cancer. The Cancer Commission, with the cooperation of the county medical society and the county branch of the American Cancer Society, and with the approval of the Council of the California Medical Association, has initiated a trial program in Riverside County of cancer detection examination in the private physician's office. The intent of the program is to make available a single clinical examination for accessible cancer, to publicize this examination, and to evaluate the results of such a program. The success of this campaign depends upon efficient cooperation of the physicians of the county, the local branch of the American Cancer Society, and the Cancer Commission. Sixty-five per cent of the members of the Riverside County Medical Society approved the plan. Indigents are to be examined in the physicians' offices or referred to the County Hospital for the examination. Final reports on the program in Riverside County are not available at the time of preparation of this report. Critical evaluation of the results will be necessary to determine the true worth of this plan.

10. The commission is seriously concerned about the increasing number of individuals and organizations claiming to possess cancer cures. A Cancer Commission statement on cancer cures and tests was published in CALIFORNIA MEDICINE in July 1951, and in the Bulletin of the Cancer Society. Copies have been sent to the various press services, and the statement has appeared in numerous newspapers throughout the state. Further and more positive action is needed to protect the people of California from the sad consequences of irresponsible and misguided practices of cancer quackery. Several of the more publicized of the so-called cancer cures are under critical scrutiny by the commission. Ways and means of combating these unscrupulous practices are being sought. A conference has been arranged with the State Department of Public Health in an effort to solve the problem. The commission solicits all possible information from the members of the California Medical Association concerning claimed cures for cancer.

The commission sincerely appreciates the cooperation and support of the President and the Council in their effort to represent the California Medical Association in the Cancer Control Program.

Respectfully submitted,

ROBERT A. SCARBOROUGH, *Chairman*

REPORT OF EDITORIAL BOARD CALIFORNIA MEDICINE

To the President and the House of Delegates:

A luncheon meeting of members of the Editorial Board was held in Los Angeles at the time of the 1951 Annual Session of the California Medical Association. The principal benefits—in addition to the opportunity it gave to members to know one another better—were that, through exchange of information and the airing of individual and mutual problems, the members and the board as a whole probably were made better able to serve the readers of CALIFORNIA MEDICINE and authors who submit material to be considered for publication.

No changes were made in the membership of the Editorial Board during the year. The members of the board are:

Chairman of the Board:
Dwight L. Wilbur, San Francisco

Executive Committee:
Albert J. Scholl, Los Angeles
H. J. Templeton, Oakland
Edgar Wayburn, San Francisco
Dwight L. Wilbur, San Francisco

Allergy:
Frank J. Crandall, Jr., Los Angeles
Samuel H. Hurwitz, San Francisco

Anesthesiology:
William B. Neff, San Francisco
Charles McCusky, Los Angeles

Dermatology and Syphilology:
Paul Foster, Los Angeles
H. J. Templeton, Oakland

Ear, Nose and Throat:
Lawrence K. Gundrum, Los Angeles
Lewis Morrison, San Francisco

Eye:
Frederick C. Cordes, San Francisco
A. R. Robbins, Los Angeles

General Medicine:
Maurice Sokolow, San Francisco
O. C. Railsback, Woodland
Edgar Wayburn, San Francisco
John Martin Askey, Los Angeles
W. E. Macpherson, Los Angeles

General Surgery:
Frederick L. Reichert, San Francisco
C. J. Baumgartner, Beverly Hills

Orthopedic Surgery:
Frederick C. Bost, San Francisco
Hugh Jones, Los Angeles

Thoracic Surgery:
John C. Jones, Los Angeles
H. Brodie Stephens, San Francisco

Industrial Medicine and Surgery:
Rutherford T. Johnstone, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, Los Angeles
Donald G. Tollefson, Los Angeles

Pediatrics:
E. Earl Moody, Los Angeles
William G. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena
Alvin J. Cox, San Francisco

Psychiatry and Neurology:
Karl M. Bowman, San Francisco
John B. Doyle, Los Angeles

Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles

Urology:
Lyle Craig, Pasadena
Albert J. Scholl, Los Angeles

Pharmacology:
Hamilton H. Anderson, San Francisco
Clinton H. Thienes, Los Angeles

Public Health:
George Uhl, Los Angeles
Charles E. Smith, San Francisco

Respectfully submitted,

DWIGHT L. WILBUR, *Chairman*

ADVISORY PLANNING COMMITTEE

To the President and the House of Delegates:

The Advisory Planning Committee has met the day preceding each meeting of the Association's Council in the past year and has discussed all items appearing on the Council's agenda as well as developing many details of the Association's current program of public relations. All items on which comment was to be made to the C.M.A. Council have been taken before that body and the Council's action on such matters has been printed as a part of the Council minutes.

During the past year the committee has been changed in its composition through the resignation of Mr. Kenneth Young as executive secretary of the San Diego County Medical Society and the appointment of his successor, Mr. William Nute. In Fresno County, Mr. Glenn Gillette, currently a member of the C.M.A. public relations staff, was succeeded by Mr. Roy Jensen, who is now a member of the committee. A third change, in Orange County, is pending at this writing, in the naming of a successor to Mr. William Tobitt, resigned as executive secretary.

Respectfully submitted,

JOHN HUNTON, *Chairman*

C.M.A. BLOOD BANK COMMISSION

To the President and the House of Delegates:

The last two links in the protective chain of our California "life line" of blood banks to serve the urban and rural population of the state have been forged. These two links are the regional Community Blood Banks in Bakersfield and Redding. The Houchin Community Blood Bank, a memorial to the Houchin family of Bakersfield, will be in operation by the end of February. It will serve the entire southern part of the San Joaquin Valley. The Shasta-Cascade Community Blood Bank is being built in Redding. It will care for the rapidly growing counties of the northeastern part of our state.

The inclusion of the above two blood banks makes a total of 12 non-profit Community Banks sponsored by the California Medical Association, implemented by the local County Medical Societies, and operated and controlled by doctors of medicine. Their sole purpose is to serve their community, their state and their nation. The strength of the system stems from free discussion, mutual assistance and respect for each bank's autonomy.

National Blood Program: Eight of our present ten blood banks (the Bakersfield and Redding banks are not quite in operation as this report is written) have contributed 188,070 units of blood to the National Blood Program—and this *at cost*. This contribution to the national cause was over and above the banks' regular civilian blood program.

Your Commission and the affiliated blood banks have scrupulously lived up to the full spirit of their contract with the American National Red Cross on the Armed Forces Blood Program. The blood banks and some of your medical societies have been confronted with needless evasions and impediments in dealing with the coordinating agency for this national program. The San Bernardino-Riverside Blood Bank and the Northern California Blood Bank have offered on several occasions to participate in the Armed Forces program and the two new banks entering the system also wish to help. The commission knows the services of our banks are needed for the all-out defense program and it intends to see that they are all enrolled.

We have insisted that our California Blood Bank system receive recognition at the national, state and local level for their role in the program. Within the state our banks should be represented with other agencies who are assisting, and we should receive joint publicity with the Red Cross. Your banks are performing superlatively in procuring, processing and distributing blood for the Armed Forces and for our civilians.

One heartening factor in the National Red Cross blood procurement work is the acceptance of federal money to compensate for the units of blood or blood plasma procured for the Armed Services. We sincerely hope that this same principle will be extended to the Red Cross civilian program, for then the major point of friction will have been removed.

Federal Civil Defense Administration: All of our system banks have pledged their full support and cooperation in aiding to create a plasma reserve for civil defense. Your chairman is a member of the State Civilian Defense Subcommittee on Blood and Blood Derivatives, and has aided in preparing a long-range plan for the state. Our banks are ready.

Unique Facility for Defense and Civilian Blood Program: On November 20, 1951, the Southern Pacific Railroad Company officially assigned SP car No. 136 to one of our member banks—the Irwin Memorial Blood Bank of the San Francisco Medical Society—for use as a traveling procurement station. The Irwin bank lends this facility to other banks within our system, for use in their areas, to procure blood for the Armed Forces and for the civilian program. The car has been altered to accommodate nine beds, canteen counter, and refrigerator. Thirty donors can be handled per hour. It will operate along Southern Pacific lines in California, Nevada, Oregon, Utah, Arizona, New Mexico and Texas, under the supervision of the blood banks and the Southern Pacific Railroad and Hospital department officials.

Financial Assistance: Non-interest bearing loans were made by the C.M.A. during the year to Bakersfield, Eureka, Riverside and San Bernardino. Repayment of former loans made to several blood banks is well under way. We anticipate that one bank, now being built, may require some moderate financial assistance. Your foresight in contributing financial assistance to medically sponsored blood banks has been a great factor in our "life line's" healthy growth. Money was never better utilized.

Meetings: The gravity of the international picture necessitated many meetings with national, state and local committees. These conferences required extensive traveling. Several invitations to appear before other State Medical Society meetings had to be refused but assistance, descriptive literature and suggestions were transmitted. Conferences were held in Minneapolis, New York, Washington and Chicago. Every blood bank within our system has been visited.

Exhibits: Our two new exhibits were shown almost constantly during the year. We exhibited at the following medical conventions: American Academy of General Practice, San Francisco, March 19-22; California Medical Association meeting, Los Angeles, May 13-16; Redding County Medical Society, September; American Association of Blood Banks meeting, Minneapolis, October 22-24; American Public Health Association, San Francisco, October 29 to November 2; California Academy of General Practice, San Diego, November 5-7; American College of Surgeons, San Francisco, November 5-9.

The great interest shown in our California system was reflected later by the deluge of requests for information. These requests have come from foreign lands and from states within our nation.

Research: We have always considered that a realistic research program should march side by side with our blood bank system's expansion.

Several of our banks pioneered and developed technical and administrative methods and many pieces of apparatus which over the last ten years have played a considerable role in making blood banking the successful enterprise it is today.

In 1952 we will embark on a more ambitious research program. Our plan calls for allocation and integration of certain phases of work which demand clarification. Research in basic issues is tremendous in its possibilities, and most provocative in its appeal.

In our blood bank program we are welded together by a common humanitarian principle. Of course our California Blood Bank System is not perfect. We are constantly learning. We are also willing and happy to transmit tested facts and methods to other out-of-state medical groups seeking assistance.

To the Executive Council, thanks. Your ready and continued support has brightened some very dark days.

To the Medical Directors of our widespread "life line" banks, grateful appreciation. Yours is the big task; you have given me unqualified assistance. You can be proud of your bank's achievements.

To the numerous technical and administrative workers and volunteers in our blood banks, a full measure of praise for the efficient, loyal manner in which you have carried on your humanitarian assignment. *You* are the Blood Bank System.

To our Commission members, my unlimited gratitude. I wish every member of our C.M.A. to know of your long hours of work, of your patient fight for medicine, but above all for the unstinting manner in which you have rendered *volunteer service*. To our volunteer administrative assistant, Mrs. Charles Hemphill, a "well done" salute.

Our report would be incomplete without our grateful acknowledgment to the hundreds of patriotic citizens, who, having faith in our "life line," have given freely of their time, their intelligence, their money and their blood to keep our non-profit system functioning smoothly and efficiently.

To John Hunton and his staff our apology for the many interruptions in their busy daily schedule. We have profited by their sage advice and been heartened by their enthusiasm.

To Hap Hassard for a thousand timely hints and for his ability to guide us through legal mine-fields and barb-wire entanglements.

It is difficult to terminate this report; there is so much which should be reported but space forbids.

Each member of our profession can and should share with us the pride of accomplishment in the following:

Blood for our Armed Forces: 189,005 units through December 1951.

Blood for *your* patients: 94,923 units for 1951.

Your Blood Bank Commission said that medicine could do the job—*it has.*

Respectfully submitted,

JOHN R. UPTON, *Chairman*

COMMITTEE ON INDUSTRIAL HEALTH

To the President and the House of Delegates:

The 1950 and 1951 annual reports of your Committee on Industrial Health anticipated a statement from the American Medical Association and other national associations of physicians and of nurses on the subject of nursing services in industry. This statement, which has been finally issued and approved by the House of Delegates of the American Medical Association, reads as follows:

ESSENTIALS OF MEDICAL NURSING SERVICES IN INDUSTRY

The status of the nurse in industry working without direct medical supervision presents an important interprofessional problem. The following statement has been prepared jointly by the American Association of Industrial Nurses, the Industrial Medical Association and the Council on Industrial Health of the American Medical Association to clarify legal and ethical principles, both for the members of interested professional organizations and for industrial employers providing any of the listed health services:

I. The value of physicians and nurses in industry depends on

(a) Training, experience and aptitude
(b) A position of authority in the industrial organization
(c) Good rapport with workers
(d) Good relations with their professional colleagues
(e) Thorough knowledge of work environment and processes
(f) Effective use of community health resources

II. A health service in industry should provide

(a) A safe and healthful work place
(b) Health counseling and health education
(c) Personal medical services as required for
    1. Observance of laws, codes and health regulations
    2. Emergency medical care
    3. Health conservation
    4. Job placement

III. Personal medical services involving the establishment of a diagnosis and the definition of treatment or the performance of specific preventive measures are functions of the physician. However, it is desirable for the nurse to participate in such services

(a) If she acts under medical supervision
(b) If she acts in an emergency

Standing orders are used to supplement rather than replace medical supervision. They are defined as a written compend of directions outlining routine medical or nursing services or procedures of an emergency nature approved and signed by a licensed physician and acknowledged by him to be services and procedures which may, in his absence, and until his arrival, be performed by a particular industrial nurse. Standing orders may constitute medical supervision if they are not an attempt to delegate the exercise of medical discretion but only delegate the execution of mechanical, clerical or administrative acts.

IV. In the absence of direct medical supervision and at the time of her employment, the industrial nurse should acquaint her employer with the legal and ethical scope of her services. If she is asked to perform services exceeding her training and licensure, she should seek advice from the nearest official medical or nursing agency.

V. In respect to industrial health services other than those listed as personal, the nurse can exercise considerable initiative. Practical limits must be based on her training, experience, and the availability of qualified consultants.

Your Committee on Industrial Health recommends that the Council consider endorsing this statement. We feel that such endorsement might lead to slightly improved relationships between the California Medical Association and the California State Nurses' Association and the industrial nurses' groups of the state.

Your committee does not feel confident, however, that the statement, as presently worded, will meet with the approval of the Council, which may wish to consider an alternative statement of possibly greater educational value to all concerned in the area of industrial medicine and nursing.

We therefore submit the following statement with the request that it be considered for endorsement, either in its present form or modified as the Council desires, for use in California and as preferable to the national statement quoted above:

NURSING SERVICES IN INDUSTRY: A STATEMENT OF PRINCIPLE

The California Medical Association recognizes the important contribution to industrial health by the members of the nursing profession through the individual activities of the nurses employed by and in industry. Through their contact with individual employees, and with members of managements, they have furthered public health education, the use of community resources, improved personal and plant hygiene, healthier psychological relationships between management and workers, and a closer liaison between the plant employee and the practicing physician.

It is also recognized, however, that demands are made upon nurses in industry by both employees and management to engage in activities which encroach upon the practice of medicine as defined by the Medical Practice Act and which, if acceded to, cause her services to replace, rather than supplement, the medical care by physicians which is demanded by the welfare of the patient, as well as being mandatory under the law.

It is urged that the nurse in industry, having met the emergency with which she is confronted, protect herself, her patient and her employer by referring the patient to a physician for diagnosis or medical care when either is required, and that further treatment be carried on only under such medical supervision. Employers of nurses are urged to facilitate such referrals and encourage them, in order that they, themselves, may be protected against being involved in violations of the Medical Practice Act.

Technicalities of the Medical Practice Act are difficult to translate into lay language and no simple definition can be given as to what services may be rendered with impunity. It certainly may be said, however, that any injury serious enough to cause temporary disability or which requires more than protective dressing, or does not respond favorably to procedures described in standard texts on first aid, will require medical treatment. It must be borne in mind that, regardless of the desires of the patient or his personal needs, or the demands of the employer in regard to industrial injuries, a nurse is forbidden by law to either diagnose or treat medical conditions or surgical injuries. It is only as this fact is grasped fully by employees and employers alike, that the pressure upon the nurse to exceed her area of function will be lessened.

Every nurse who is aware of the Medical Practice Act and its implications may become involved in a violation of an official interpretation. To ignore the act and its limitations is to invite inevitable violations.

The California Medical Association anticipates and welcomes the further extension of employment of nurses in industry in view of their tremendous contributions both to the over-all health welfare, and to the physical and emotional comfort of employed individuals. It looks forward to cooperating fully with the California Nurses' Association and the official industrial nursing groups in establishing and maintaining the area in which the professional industrial nurse may function effectively, efficiently, ethically and legally.

Respectfully submitted,

CHRISTOPHER LEGGO, *Chairman*

COMMITTEE ON RURAL MEDICAL SERVICE

To the President and the House of Delegates:

The activities of this committee were somewhat delayed due to the rather late appointment of the chairman.

The most pressing problem on the agenda of this committee's activities is an evaluation and correction of the health facilities for the migratory workers in the state. In connection therewith, a program for the approach to this problem is under way whereby health facilities for the seasonal and migrant worker may be determined. It is planned to make use of all agencies and organizations interested in this problem. Committee members throughout the state are being asked to evaluate their local problems and suggest means of correction. Use of the Governor's special committee's survey on migratory labor conducted in 1951 will be made. Official health agencies such as county health departments will be asked to assist in the work of this committee. There is little doubt that at the present writing there is need for considerable improvement in the health and medical services in this group of California's population. It is our sincere hope that the work of this committee will serve to correct much of the existing deficiency.

While the problem of the itinerant or migrant worker is essentially the most vital one for the present, there is also the ever present demand on the part of farm organizations for greater spread of medical care. Although this problem in its strict sense is not within the province of this committee, it would appear that some thought and consideration should be given it by cooperation, if not liaison, with other groups, particularly those committees of the C.M.A. charged specifically with this assignment.

The chairman has had the opportunity and privilege of sitting with the A.M.A. Committee on Rural Health and plans to attend the conference on Rural Health to be held in Denver the latter part of February.

Respectfully submitted,

H. A. RANDEL, *Chairman*

C.M.A-C.P.S. LIAISON COMMITTEE

To the President and the House of Delegates:

The committee acted favorably on the matter of C.P.S. providing a complete medical and hospital program for designated beneficiaries in the Sailors' Home of the Pacific. No other matters were referred to the committee.

Respectfully submitted,

H. GORDON MACLEAN, *Chairman*

C.P.S. STUDY COMMITTEE

To the President and the House of Delegates:

The entire committee of 15 has devoted many week-ends to an analysis of this very complex problem. A further report will be made at the annual meeting.

Respectfully submitted,

WILBUR BAILEY, *Chairman*

REPORT OF THE C.P.S. FEE SCHEDULE COMMITTEE

To the President and the House of Delegates:

The 1951 C.P.S. Fee Schedule Committee, appointed by the Council of the California Medical Association and known as the "Committee of Eight" was finally named in September, 1951. It was instructed to present in December, 1951, to the interim meeting of the House of Delegates, a fee schedule based not on the low income group fees as the present schedule is, but on the average fee for the average patient throughout the state of California, whether treated by specialist or general practitioner in rural or urban areas; a fee schedule to please all doctors under C.P.S.; and a schedule possible of ratification by their duly elected delegates to the House. This was a large order. The committee's work was simplified only by the directive that it was to deal with fees alone and not with policy such as the type of contract, question of indemnity, premium rates, etc., or what percentage of such a new higher fee schedule could be paid by present premium rates.

The "Committee of Eight" reviewed all the vast amount of work of the previous C.M.A. Fee Schedule Committees, and the fee schedules of all other state plans available; carefully considered all correspondence accumulated by past committees from various groups within California, and tabulated the fees of the present low income schedule

of September 1, 1949, as compared with the Frey Schedule presented to and rejected by the House in May, 1951. It then decided that to merely inject eight new personalities into the picture was useless and that the opinion of not just the delegates, but of the physicians practicing under C.P.S. should be sought. Therefore, a questionnaire showing the present low income groups fees and the printed Frey Schedule fees was sent to every physician member of C.P.S., with directions that if the physician wished to change any of the Frey fees he should list his suggested fees in the specified column, and if he did not know or care what a given fee should be, or was willing to work under the Frey schedule, he should leave the column blank. In this way a blank vote showed the willingness of the doctor to work under the Frey schedule. An I.B.M. card was then cut for every changed fee suggested by every physician, a matter of 79,460 cards. In order to get this done and tabulated by the December meeting, and knowing the ability of the busy doctor to postpone what does not have to be done at once, the committee set a tentative short deadline. The results were amazing. In the first five days more than 1,700 of the 11,000 questionnaires were returned and 2,780 were received in time for processing and study prior to the report; and slightly fewer than 700 came in later. In the questionnaire instructions, it was stated that if the physician was willing to work under the Frey schedule as printed he need not return the form at all. Hence it might be questionably assumed that the 7,000-odd physicians who did not return their forms approved the Frey schedule.

The committee carefully studied the I.B.M. tabulated returns of the questionnaires and found that if the returns were counted strictly as votes, the Frey schedule was accepted by a wide majority in every item, more than 2,100 physicians having voted for the approval of each. However, the committee recognized that a blank vote for a given item meant either approval or disinterest. Therefore it scrutinized the changes requested for each item and the trend up or down, collated the trend with the specific requests from groups, seasoned these changes with its own eight-man judgment, and arrived at a new fee schedule slightly different from the Frey schedule in some items. To show how this was done, a few samples are important. One of the greatest unit costs to C.P.S. is the office visit. This will vary from a "shot" visit or a simple dressing by a doctor or his nurse, to a prolonged interview or work-up. The item No. 011—"Follow-up Office Visit," was set in the Frey schedule at $5.00. In the survey, 2,359 doctors approved this by not voting for a change. However, 378 doctors considered it too high for the average case and felt it should be lowered on the average to $4.00. Thirty-six thought it should be raised. The suggested fees ranged from $5.50 to $15.00, and the mean was $6.00. Your committee studied the matter carefully and came up with three different categories of office visits and fees: $3.00 for the simple "shot or dressing visits," $4.00 for the routine visit, and $6.00 for the follow-up office interview, with the number of visits limited to one a week. Consideration of this kind was given to each item. Some were raised in spite of a clear "vote" for the Frey schedule because of a heavy "vote" to have it raised by the men doing the procedure, and others were slightly lowered for the same reason. For certain items, such as consultations, and appendectomy with various types of pathologic change, variable fees, as for the office visit, were arrived at by the committee. Other items show wide variability such as a cut tendon repair which was given no set fee and these were referred to the Medical Policy Committee. Many new items were added.

The committee realized that there could never be a perfect fee schedule, but its schedule which it considered to be close to the "will of the people" was presented to the interim session in December, 1951. This schedule was again turned down by the elected representatives of those people and referred back to the committee as "immature."

It is important to review the arguments used in referring this schedule back to the committee. The first came from a group of orthopedic specialists who spoke against the "total fee" for a given procedure on which the printed Frey schedule and the new fee schedule were based, stating that the long-winded ramifications of orthopedic cases made a "total fee" for a given case impracticable. Your committee had considered that carefully and endeavored to set the fee for the average case and made allowance for special cases by appealing to the Medical Policy Committee, realizing that a fee schedule must either be on a "total fee" basis for all surgical cases or none and that to set a fee for surgery only and then allow a follow-up visit for each postoperative call would greatly increase the paper work in the C.P.S. office and cut down the unit value to all doctors in turn. Perhaps the committee was wrong.

Another argument was that all the "votes" did not get counted in time and therefore the schedule was "immature." The 700-odd votes not tallied could not possibly have changed the figures. They are now being tabulated. The third argument was that inasmuch as the Trustees had just announced the 100 per cent pay on the old low fee schedule, the new schedule should not be accepted in spite of the previous directive of the House of Delegates to have a schedule prepared on the average fee rather than the low fees of the September 1, 1949, schedule. Is this logic? The fourth argument was that inasmuch as $40,000 was being appropriated to another Study Committee to investigate all the policies of C.P.S. in the future, a new schedule should not be adopted in the meantime.

So the "Committee of Eight" has the schedule back and at the present writing is contemplating its next move. Be assured its members have no axe to grind with any man or group. They are trying to perform a nearly impossible job of pleasing all the physician members of C.P.S. and their elected representatives at once with a "mature" fee schedule; and, as they suspected, they are still "behind the eight ball" and will probably remain there until the will of the House of Delegates crystallizes or they are relieved from duty by another committee.

Respectfully submitted,

Ralph D. Anderson
DeWitt K. Burnham
L. H. Fraser
Darrell Overpeck
Dudley Saeltzer
T. Philip Sampson
L. J. Tragerman
A. Justin Williams

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

San Diego County.

Francis E. West, San Diego, *Councilor.*

San Diego County Medical Society

The most outstanding event during the year was the Complete Service Bureau-San Diego County Medical Society lawsuit coming to trial. It will be recalled that on October 15, 1948, the Complete Service Bureau, a prepaid medical service corporation, filed suit against the San Diego County Medical Society. In its complaint the Service Bureau charged that three doctors on its staff were denied membership in the society without cause. C.S.B. and the three doctors asked damages of approximately $100,000. They also requested that the County Medical Society be permanently restrained from refusing membership to them and discriminating against them in other respects.

The medical society denied the allegations and in addition, filed a cross complaint charging the Complete Service Bureau with establishing an overlapping corporate set-up which created a situation whereby the staff doctors were advertising for patients and splitting fees in violation of state law.

The trial opened September 11, 1951, before a superior court judge in San Diego. C.S.B. dismissed its request to have its doctors admitted to the society and the case proceeded to trial on the medical society's cross complaint. After a ten-day trial, the case was submitted to the Judge on written briefs. Oral argument is to be had early in 1952, and a decision will be forthcoming shortly thereafter.

Mr. K. C. Young, executive secretary of our society for the past five years, tendered his resignation, effective Nov. 1, 1951, to accept a position with the Los Angeles County Medical Association as assistant executive secretary. He took with him the good wishes of all members of our society. Numerous applicants were interviewed for the vacated position, and William T. Nute, of San Francisco, was selected. Mr. Nute's broad experience in medical matters will serve him well in his new position.

Considerable time has been devoted to studying the reader interest of our bulletin. As a result of a survey made on this subject, the staff of the bulletin has made various changes in style, cover, topics for articles, etc., in order to conform with the wishes of members of the society.

The program committee has been most active in obtaining outstanding medical lecturers and professors from schools of medicine to appear as guest speakers at the monthly society meetings. The attendance at these meetings has steadily increased as a direct result of the interest shown in the speakers and their subjects.

The general practitioners in San Diego County were hosts in November to the California Academy of General Practice when the Academy held its annual meeting at Coronado. Many physicians in this area took advantage of the proximity of the Convention to attend one or more of the sessions.

The growth of the membership of the society has been tremendous during the past year. There are at present 66 applicants for membership serving their one-year probationary period. Their acceptance will result in a total membership of 585, making this society the fourth largest in the state.

W. H. GEISTWEIT, JR., *Secretary*

SECOND DISTRICT

Imperial, Inyo, Mono, Orange, Riverside and San Bernardino Counties.

John D. Ball, Santa Ana, *Councilor.**

Imperial County Medical Society

The problem of Civilian Defense received special emphasis during the past year by two full meetings of the county medical society being devoted to addresses on treatment of casualties of an atomic attack and the role of the hospital in civilian defense.

Along with the growth of the society there has been a gradual emergence of plans for development of a more comprehensive public relations program in the near future.

The society holds its regular meetings the second Tuesday of each month at 8 p.m. at the Pioneers Memorial Hospital. The scientific program is followed by a business meeting.

ERNEST BROCK, *Secretary*

Inyo-Mono County Medical Society

The year 1951 has been a very interesting year for the Inyo-Mono County Medical Society. We have had 12 meetings during the year and had guest speakers at nine meetings.

Several new members have joined. The attendance has been about 90 per cent of membership.

The interest in public health has been greatly improved. We feel that Inyo-Mono County Medical Society has had a very successful year in 1951.

J. CARL CUMMINGS, *Secretary*

Orange County Medical Association

Perhaps the most significant development during 1951 in our society's over-all public relations program was the appearance of our first advertisement promising doctors' services regardless of inability to pay, announcing the existence of a board of appeal to which the public could turn when it felt it had been overcharged or otherwise unfairly treated, and reannouncing our service by which doctors were secured in emergencies by calling our headquarters number at any hour of the day or night.

We believe that these three services and functions of our association are definitely in the public interest and in advertising them we were announcing genuine accomplishments, not just making empty promises. We had set the foundation for them more than two years ago and we had that much clinical experience behind us.

The advertisement was a one-column by 18-inch display that appeared in every daily and weekly newspaper in the county in the week of October 8, 1951.

Significantly, at this writing, more than two months later, our central office had not received one report, as a result of the advertisement, of anyone being denied medical care for financial reasons or a complaint on fees. This was directly contrary to the pre-advertisement fears expressed by some members that there would be a "flood of complaints."

During the year our general meetings continued to draw excellent attendance, with our members being benefited by talks on such diversified subjects as the medical aspects of atomic warfare, cancer, diabetes, potassium metabolism, hematuria and tuberculosis in addition to presentations on legislative matters, California Physicians' Service and an appearance before us of the state president, Dr. H. Gordon MacLean.

Our county, despite its being somewhat removed from the "critical target area" category, is well organized medically in the event of disaster, either man-made or otherwise, with each community's medical personnel definitely assigned to posts and with a cooperative plan ready to roll should our neighboring Los Angeles County suffer a major catastrophe while we were remaining comparatively free from harm.

Our membership has continued a small but steady growth in step with the gradually increasing general population. At year's end our roster encompassed 210 active members, plus an additional 15 applicants due for processing early in 1952.

CHAD M. HARWOOD, *Secretary*

Riverside County Medical Association

The annual doctors' and wives' banquet of the Riverside County Medical Association was held December 1 at the Victoria Country Club in Riverside. A golf tournament preceded the banquet.

The association meets the second Monday of each month at the Mission Inn in Riverside. A scientific program is presented after the business session, and light refreshments are served at the conclusion of the evening.

A bulletin of pertinent news and information for the members is published each month.

RICHARD N. BOYLAN, *Secretary*

San Bernardino County Medical Society

The most notable change made in our society during the past year has been the adoption of a new constitution and by-laws, which is a modernized version of our old one and conforms to the Constitution of the California Medical Association.

*Dr. Ball died Dec. 20, 1951.

It has been voted to set aside a certain amount of money each year for a building fund.

Our society continues to grow, and we have many activities which are handled by our secretary.

A majority of our members are now in the group policy for malpractice. In addition, we have a health and accident insurance which furnishes coverage to our members at a reduced rate.

Members are taking an active interest in our society, and our meetings are extremely well attended.

The blood bank has been one of our big achievements. The first six months show that 4,525 donors have been drawn and blood processed. This blood bank was set up as a community venture. The doctors of San Bernardino and Riverside counties donated almost $10,000 as a nucleus. This, with the help from the public and a loan from the California Medical Association, has insured a sound foundation. The blood bank is now making money and is able to repay some of this loan. Plasma will be available in the near future. Our blood bank proved that a locally sponsored bank is the best type.

CARL M. HADLEY, *Secretary-Treasurer*

THIRD AND FOURTH DISTRICTS

Los Angeles County.

H. Clifford Loos, Los Angeles, *Councilor,* Third District; J. Philip Sampson, Santa Monica, *Councilor,* Fourth District.

Los Angeles County Medical Association

One of the most active years in history has just come to a close for the Los Angeles County Medical Association. With its membership at an all-time high of 5,102, the association has made an all-out effort to furnish a strong and effective guiding hand for the local members of organized medicine.

The highlight of the past year—from the standpoint of effective organization and execution of a complex problem—was the association's hosting of the American Medical Association's Clinical Session from December 4 through 7. Visiting physicians from all over the nation were unanimous in the opinion that the interim session was one of the finest on record, with scientific exhibits and lectures all keyed to the broadening of the general practitioner, as well as the specialist.

Another individual accomplishment of the association during the past year was the approval and establishment of a grass-roots public relations program, with three primary goals: (1) improvement of the doctor-patient relationship, (2) bolstering medical prestige throughout the community, and (3) bringing the association's far-flung branches into closer contact with the parent organization. In cooperation with the state's expanded public relations activities, it is hoped that this program will go into high gear during 1952.

The association's civil defense committee continued to lead the way for other comparable groups throughout Los Angeles County. Under the leadership of Dr. Frank Schade, the committee has set up a blueprint against disaster in the event that all-out war should ever hit this area and has become one of the most active committees of its kind in the nation.

In the same field of community betterment, the association's smog committee—guided by Dr. Francis M. Pottenger, Jr.—has continued to probe the causes and cures of the contaminated air which has come to plague this area during the past year. Although progress is necessarily slow in such a complicated problem, this group looks forward to recognition and assistance in its admirable efforts during the coming year.

Due to the skyrocketing of costs connected with any new building operations, the association has temporarily abandoned original plans of constructing an entirely new building for its offices and library. Instead, as an economic measure, it is likely that the existing structures will be enlarged and rearranged to the extent that thousands of dollars can be saved, yet—at the same time—still accommodating the association's greatly-expanded operations for several years to come.

For the first time, the revised constitution and by-laws were brought into effect in the association's recent elections for general officers, trustees, and councilmen. Under the new setup, the trend of bringing the 13 outlying districts into closer contact with the metropolitan area was greatly assisted by adding new and fuller representation to the council. In the same direction, there has been established a monthly conference of branch officers, which serves to keep the outlying areas in contact with what their central organization is attempting to do in their behalf.

PAUL D. FOSTER, *Secretary-Treasurer*

FIFTH DISTRICT

San Luis Obispo, Santa Barbara and Ventura Counties.

A. A. Morrison, Ventura, *Councilor.*

San Luis Obispo County Medical Society

The following information is a synopsis of the activities of our society for 1951:

The San Luis Obispo County Medical Society held ten meetings during the year 1951, two were social, one was a postgraduate meeting and seven were a combination of scientific and business meetings. Meetings were well attended and the scientific discussions by guest speakers were received with enthusiasm.

The San Luis Obispo County Medical Society has continued to be an active backer of the Tri-County Blood Bank.

The society has established a grievance committee and a public relations committee.

Nine applicants were elected to membership in the society during the year. Total active membership now is 47, and our society will have two delegates at the C.M.A. convention.

The medical personnel of Camp Roberts have been invited to attend our medical society meetings. They have reciprocated by being host to our society on two occasions.

JOHN H. WOODBRIDGE, *Secretary-Treasurer*

Santa Barbara County Medical Society

The society at present numbers 155 members and has completed a very successful year under the presidency of Dr. H. Verrill Findlay. During the year 19 new members were elected to the society. Seven members transferred to other cities.

During the year the officers of the society have been kept busy with various projects. The rewriting of the constitution was undertaken under the guidance of Dr. Laurence M. Heiges. An excellent program was furnished by the postgraduate committee, and the lectures were well attended. The 12-week course which the University of Southern California School of Medicine offered was also a great success. During the year we have had many outstanding speakers for the scientific portion of our meetings which have been of educational benefit to our group.

We are now looking forward to a busy and interesting year under the guidance of our new president, G. Horace Coshow, and president-elect, W. C. Graham. Our officers elected at the December meeting were: President, G. Horace Coshow; president-elect, Walter C. Graham; secretary, Lawrence M. Nelson; secretary-elect, Arthur E. Wentz; treasurer, Francis B. Zener.

LAWRENCE M. NELSON, *Secretary*

Ventura County Medical Society

The Ventura County Medical Society held 12 meetings during 1951. Meetings are held on the second Tuesday of each month at the Colonial House in Oxnard with the exception of the Annual Meeting in December which is held at the Ojai Valley Inn.

On October 9 we were honored by a visit from Dr. H. Gordon MacLean, president of C.M.A., who discussed public relations.

The Public Relations Committee, with C. A. Smolt, M.D., as chairman, has been very active. A grievance committee has been formed and will function in 1952. A conference was held with the editors of all the newspapers of the county and the directors of the radio stations, with the purpose of improving press relationships and cooperation, and a "minimum code of cooperation" was adopted. The society passed a resolution opening all meetings of the society to accredited members of the press.

Foster Memorial Hospital in Ventura has completed its 20-bed maternity wing addition and St. John's Hospital in Oxnard is completing its 75-bed addition. The Ventura County Hospital has started excavation for a 75-bed addition and new surgical, x-ray, laboratory and out-patient clinic facilities.

The following officers were elected to serve for the year 1952: President, J. R. Monahan, Oxnard; president-elect, J. M. Hunter, Ventura; secretary, F. K. Helbling, Ventura; and treasurer, R. E. Williams, Camarillo.

FRANKLIN K. HELBLING, *Secretary*

SIXTH DISTRICT

Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties.

Neil J. Dau, Fresno, *Councilor.*

Fresno County Medical Society

The society's program of committee organization, coordination of projects and emphasis on internal relations as well as public relations has continued to be our basic objectives in 1951. Early in the year an immunization program, with the full cooperation of society members, was put into operation. All phases of doctors' and hospitals' participation in the Fresno civil defense program were completed and details worked out for the coordination of medical facilities in the event of a major disaster. Close cooperation has been maintained with the Valley Blood Bank and the Red Cross in the national defense blood program.

A local chapter of the American Heart Association was organized. Pursuant to recommendations made by the 1950 library committee, the medical library of the society merged with that of the General Hospital and is now in operation. The number of members covered under the society's group malpractice program was almost doubled in 1951 and monthly disability benefits were increased under the society's group health and accident program. A medical advisory committee was appointed to assist in the administration of the Valley Children's Hospital currently under construction in Fresno. This committee will form the nucleus of the medical staff during the construction period and thereafter.

Every effort has been made to schedule monthly scientific programs that would be of interest and value to general practitioner and specialist alike. A different field of medicine has been discussed at each meeting and attendance at these meetings has been good.

The speakers' bureau continued active with increasing numbers of talks given by society members on medical and medico-economic subjects throughout the valley. Newspaper coverage of society activities and its members has been good. The society's office has continued to aid the public in securing doctors in emergencies, arranging for referral of patients to doctors, disseminating data concerning health insurance, medical schools, hospitals, medical society policy, public health matters and various other public services. Several safety campaigns have been endorsed and sponsored by the society. Particular attention has been paid to legislation in Sacramento and Washington affecting the public health and welfare and direct representation made to our legislators.

The second annual San Joaquin Valley Medical and Surgical Institute, cosponsored by the C.M.A., was held in October. A record-breaking attendance attested to the success of the institute. The Fresno Chapter of the American Academy of General Practice has functioned primarily to further scientific instruction, the emphasis having been switched from entertainment to teaching, both by medical school instructors and local specialists.

The committee on professional relations has continued to serve as a judicial body in indicating to the profession and the public various standards of medical practice and procedures in the community regarding ethics, fees, etc. The committee has investigated and upon request, arbitrated any matters of dispute, controversy or grievance arising between members, or between patient and doctor, and has advised in cooperation with all those concerned. A serious and conscientious effort has been made to protect the interests of the public, but at the same time, no arbitrary rulings or undue pressure has been exerted which would adversely affect the physicians' individual rights. Functions of the committee have been judiciously publicized and both members of the medical profession and the public alike are becoming more cognizant of the society's efforts to arbitrate complaints in a just, unbiased manner.

The Woman's Auxiliary continued active in many fields of aid to the profession and service to the public. Recruitment of student nurses, ID tags for children, national blood defense program, aid to nurses at the county hospital—these were some of the Auxiliary's constructive activities.

The society has continued in its study of a solution to the health problems on the west side of the San Joaquin Valley. Early in the spring a meeting was held with various other agencies for the purpose of acquainting the Field Director of the A.M.A.'s Committee on Rural Health with the west side migrant situation as it relates to medical care and public health. The society has worked in close cooperation with the Public Health Department and the Fresno County Coordinating Council in an effort to improve the health conditions of the labor camps in this area and has studied and endorsed the policies and procedures for the operation of rural health clinics. In other matters pertaining to public health, the society approved the fluoridation of community water in Fresno and Madera counties; recommended the support and the development of a course for practical nurses at the County Hospital and the Fresno Junior College; made a survey of rest homes in the community and pledged its aid in combating the narcotics racket. There has been an effective liaison between the medical profession and organized groups interested in cancer, heart disease, tuberculosis, infantile paralysis, crippled children, etc.

Active membership increased from 217 to 230; total membership from 243 to 259. Several members entered the military service.

DEAN L. HYDE, *Secretary-Treasurer*

Kern County Medical Society

The doctors of Kern County, through their organization, the Kern County Medical Society, have during the year 1952 worked hard through various means to demonstrate to the people of the communities of the county the good will that the doctor has toward his patient and toward his community.

One of the major achievements of the year has been the establishment of the Houchin Community Blood Bank, which will serve all of Kern County. Through the efforts of the Board of Directors of the non-profit corporation consisting of Drs. Hall, Osell, Varney and Vaughan, and lay members of the community, the bank has become a reality and will be in operation by the end of the first quarter of 1952. The construction of the building has been made possible through the generosity of a citizen of Kern County, Mr. Elmer Houchin, who contributed funds for its construction.

The society again participated in the Kern County Fair through the Hall of Health that it originated. By distribution of pamphlets and talking with patrons who passed through the Hall of Health, an effort was made to create good will for the medical profession. Pamphlets and discussions were directed toward informing the public of the activities and services of the doctors of the county, explaining the doctors' stand on socialized medicine and the part that the doctors are playing in providing leadership and advice in the development of community improvement projects. The Hall of Health and the medical society exhibit were awarded a blue ribbon by the judges of the county fair for the high quality of the demonstration.

The Hospital Committee of the society followed through with the necessary preliminary steps to bring about the construction of a new 100-bed hospital to serve the Bakersfield area. Following up the hospital survey report, a Founders' Committee was organized, a board of directors selected, and the Greater Bakersfield Memorial Hospital Association incorporated. Application was made for grant-in-aid under the Hill-Burton Act. The medical society committee and the board of directors of the hospital association are still working cooperatively with the hope of consummating this plan in 1952.

In cooperation with the American Cancer Society and the Cancer Commission of the California Medical Association, the cancer committee provided the doctors of the county with a one-day cancer symposium.

Through their monthly meetings, the doctors were given an opportunity to hear outstanding teachers in the field of medicine, as the program committee provided each meeting with a speaker on medical subjects.

The grievance committee, established for the purpose of hearing complaints of the public in an effort to establish better relationship betwen doctors and patients where misunderstandings might exist, went into action, hearing and adjudicating six cases.

The relationship between the doctors of Kern County and the Kern County Hospital has gone smoothly. The doctors are providing the hospital with a visiting staff and a consulting staff to the extent of more than 8,000 medical care hours. It is estimated that this service has saved the county taxpayers approximately $250,000. It is hoped that soon, with good will firmly established, the liberal admittance policy of the county hospital may be corrected. This depends greatly, however, upon whether or not more voluntary private hospital beds are made available in the community of Bakersfield.

Medical Economics Council of the Kern County Medical Society, through increased activities and increased revenues, has effected a reduction of $25 in the dues for 1952. The collection activities, through forced contacts with dissatisfied patients, have, without question, been instrumental in promoting good public relations that might be lost through lack of contact.

The doctors of Kern County cooperated with the California Physicians' Service during the period of separation from Blue Cross during the past year, giving C.P.S. needed approval through signing a letter which was used in contacting organizations insured jointly by C.P.S.-Blue Cross. It is believed that this letter was of help in convincing businesses to continue with C.P.S. coverage.

Through the efforts of the doctors as individuals during election times, the society now enjoys the comfortable situation of having friends in local, state, and national offices. This increasingly important factor points with some assurance to improved conditions and public relations for the doctors of Kern County for the ensuing year.

ROBERT W. SHELDON, *Secretary*

Kings County Medical Society

The annual meeting of the Kings County Medical Society was held December 20, 1951, at Peden's Cafe in Hanford.

The society meets on the third Thursday evening of each month at various places throughout Kings County. Dinner is served, followed by a short business session and a scientific program.

WILLARD S. BRIDWELL, *Secretary-Treasurer*

Merced County Medical Society

During 1951 the society adopted and placed in use a new constitution and by-laws, replacing the out-dated procedure which had been in force before.

No new members were admitted to the society during the year and three men were dropped, two by transfer and one by death.

The following officers were elected for the year 1952: President, J. J. Wolohan, Livingston; president-elect, E. M. Soderstrom, Merced; secretary-treasurer, Harry R. Maytum, Merced; board of governors, C. C. Fitz-Gibbon, Merced; E. H. Koepke, Merced; W. E. Fountain, Merced; G. Pimentel, Los Banos; A. E. Jackson, Merced; John East, Dos Palos; delegates: E. A. Jackson and G. Pimentel, Los Banos; Alternates: Shelby Hicks, Merced; and Hugh Haas, Dos Palos.

Regular meetings are held the fourth Thursday of each month at the Hotel Tioga in Merced at 7:15 p.m. and visiting M.D.'s are always welcome.

HARRY R. MAYTUM, *Secretary-Treasurer*

San Joaquin County Medical Society

Dr. D. C. Harrington served as president of the society in 1951. Activities of the society during the year included:

1. A continued effort was made to launch an executive secretary program in the county. On a vote the plan was defeated by a very small margin. However, later in the year the society authorized the board of directors to secure an office for the society and to engage a full time paid assistant to the secretary.

2. The draft in final form of a new constitution and by-laws for the society was passed. This has entailed a great deal of work by the committee headed by Dr. Virgil Gianelli.

3. From September to November the postgraduate study club presented its annual series of eight lectures on scientific subjects of general medical interest. Dr. Louis P. Armanino was in charge of arrangements.

4. There has been cooperation by our members with American Cancer Society. About one hundred addresses have been given to lay groups during the year.

5. Dr. D. C. Harrington, our representative to the Red Cross Blood Bank, reports the bank has had its biggest year. Two bloodmobiles and a special blood train are in service and in one month, in excess of six thousand pints of blood were drawn.

During the year two of our pioneer members died: Dr. Jesse W. Barnes, who practiced in Stockton from 1919 to 1943, and Dr. Homer D. Rose, who practiced in Sonora from 1915 to 1943. Four of our members, Drs. Allred, Hopkins, Low and Hannah were called to military service. Dr. Oliver P. Riggle has been unable to practice during the past year because of illness.

There has been a net gain in membership of 12 during the year 1951, making a total membership at this time of 161.

FRANK A. MCGUIRE, *Secretary*

Tulare County Medical Society

The Tulare County Medical Society, composed of 79 members, had a most successful year with a considerable number of new activities in the year 1951 under the leadership of President James E. Feldmayer of Exeter. Regular monthly meetings were held as usual in the county, and another successful ladies' night was held at the Martin Memorial Building in Springville.

During the year, the new constitution and by-laws were approved, making the business transactions much more streamlined since the newly-formed board of governors were able to transact most of the routine business matters without taking time from our regular monthly scientific meetings.

During the year Dr. Gerald Casebolt entered the armed forces, Dr. Charles M. McClure remained in the service, and Dr. William D. Clinite, who had served several years in the U. S. Naval Reserve, completed a second tour of duty and returned to private practice in Tulare.

During the year an emergency arose at the Tulare County Hospital when the entire medical staff suddenly resigned, making it necessary for the Tulare County Medical Society to furnish a temporary emergency staff under the leadership of Dr. Elmo Zumwalt of Tulare. A complete reorganization of the medical staff at the Tulare County Hospital was accomplished, and more than 50 per cent of the members of the Tulare County Society are now cooperating as visiting staff members to the county hospital, making the medical program considerably more interesting to the resident staff, and also improving the quality of medical care in the county hospital considerably.

Another new activity was the introduction of a monthly study group which meets at the new Tulare District Hospital for discussion of medical subjects and clinical pathological conferences. Also, the postgraduate activities committee was active during the year, and was successful in bringing to Visalia and Tulare County a postgraduate seminar which met Sunday, October 14, 1951. Attendance at this meeting was very gratifying and the program was excellent. Also, a seminar on cancer was held at our regular monthly meeting September 27, 1951, at which time Drs. John Budd, Moris Horwitz and Lewis Guiss presented a symposium on cancer in accessible sites. During the year a liaison committee from the Tulare County Medical Society was active in working with the sheriff-coroner's office of Tulare County in an attempt to improve relationships between the physicians and the coroner's office and to establish a medical examiner type of program in Tulare County. It is hoped that this program will be worked out during the coming year.

Officers elected at our regular December meeting on December 20, 1951, are: J. H. Brady, president; Vincent M. Dungan, vice-president; Robert D. Karstaedt, secretary; and Victor A. Badertscher, member of Board of Censors.

J. H. BRADY, *Secretary*

SEVENTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties.

Hartzell H. Ray, San Mateo, *Councilor.*

Monterey County Medical Society

Nineteen fifty-one was a very busy year for the Monterey County Medical Society. Six new members were accepted into the active membership, one member retired, three moved away. The total membership is now 118.

This year marked the first year of operation under the new constitution. The society became incorporated under the laws of California.

A group health and accident policy was instituted and widely accepted.

The Society took an active part in the formation of the rules and regulations which would instrument the formation of a staff of the new Salinas Valley Memorial Hospital, which will begin operation in late 1952. The medical society through its executive council is taking a more active part in community affairs in problems affecting health and welfare.

Many new doctors have moved into the county and during 1952 the membership will pass the 120-125 mark.

The new officers for the year will be Ray V. Rukke, president; H. M. Stufflebam, president-elect; Frank P. Cusenza, secretary; and John R. Marron, treasurer.

HOWARD C. MILES, *Secretary*

San Benito County Medical Society

On Thursday evening, October 18, 1951, a banquet was held at the Holland Hotel in Hollister for the doctors and their wives. Guest speaker of the evening was Dr. L. A. Alesen, President-elect of the C.M.A. Other guests were Dr. Hartzell Ray, Councilor from San Mateo, and Messrs. Ed. Clancy and G. W. Gillette from Public Relations of the C.M.A.

Cocktails were served at the home of Dr. R. Hull, County Health Officer, prior to the banquet. The evening was greatly enjoyed by all and it is hoped to make such an event an annual affair.

The county society holds regular monthly meetings on the third Thursday of each month.

R. E. BROWN, *Secretary*

Santa Clara County Medical Society

The year 1951 witnessed greater activity on the part of the Santa Clara County Medical Society and its officers than occurred in any previous year. Many basic policies formulated in the three previous years, in particular, were furthered by action of the Council and the various committees. During the year there were 13 Council meetings (of approximately five and a half hours' duration each), and 66 committee meetings, with a total member attendance of 554.

During the year, 30 applicants were elected to regular membership, seven to associate membership, and five to affiliate membership. Regular memberships as of November 1 totaled 346, with 29 applications still pending. In compliance with Council request, the firm of Logan and Frazer was engaged to provide a monthly auditing service, and to revise the accounting system to provide more uniform reporting on the society and bureau business as suggested by the executive secretary. This was deemed advisable in view of the fact that currently the two organizations' combined financial transactions during the year exceed $200,000.

The scientific meetings arranged by the program committee were especially well attended and received each month. The choice of subjects and speakers made by the committee has earned numerous compliments. The June golf party was a success, and over 300 persons attended the president's dinner on December 10. This annual dinner marked the 75th anniversary of the founding of the Santa Clara County Society.

The Committee on Hospitals and Related Groups again concerned itself with the problems of standardizing procedures in the various local hospitals, and during the year the executive committee held informal talks with hospital staff leaders in an effort to develop closer liaison between the programs of the various hospitals and the medical society.

In the early part of the year the Code of Cooperation for use between the society and local voluntary health agencies as proposed by the public health committee was adopted by the society. The Council also approved the committee's recommendation to assist and work with the State Department of Public Health in conducting a morbidity study among residents of San Jose. The society sent three official representatives to Sacramento in October to attend the Governor's Conference on "Problems of the Aging." Attention was given to the problems of helping to develop a new administrative code for the County Health Department and County Hospital as required by the terms of the new county charter. The Council assisted the County Board of Supervisors in the selection of four physicians to serve on the newly established Health and Welfare Commission of the county.

As it has for the past three years, the Council took an active and progressive interest in the affairs of the San Jose-Santa Clara County Emergency Aid Station in San Jose. Attempts to destroy the present system of a publicly administered emergency aid service by leasing it to private hospitals was successfully combated by the Council. The society's committee on the emergency aid station continued its effort to improve the services provided, and has earnestly sought to secure a more favorable location for the station.

The work of the Civilian Defense Committee was chiefly one of unifying the various interests and in coordinating the various complex responsibilities. The committee published a booklet listing all civilian defense aid and mobile stations and made the booklet available to all members of the medical personnel division of the county's civilian defense administration. The committee assisted in establishing training courses for nurses and instructors in civilian defense activities. It considered and established policy on matters of blood typing and immunization.

The Military Liaison Committee busied itself all year with various individual and personal situations brought about through the medical personnel draft registrations of both October 1950 and January 1951. The statistical work of compiling current reports on every draft registrant physician in the county was, of itself alone, a tremendous task.

The public relations committee again ably carried out its assignment of publicizing medical society policy regarding the availability of medical care for persons unable to pay for it, and published four special advertisements on the subject of "Plus Values of Voluntary Health Insurance." These advertisements appeared in San Jose, Sunnyvale, Mountain View and Palo Alto papers, and in the weekly A. F. of L. *Union Gazette*. During the early portion of the year members of the committee worked closely with representatives of the California Medical Association in matters before the State Legislature in Sacramento. The committee maintained an exhibit at the county fair which publicized voluntary health insurance, and more than 3,000 persons were given tickets for a free chance on a one-year paid-up policy with Blue Cross.

One of the major subcommittees under the standing Committee on Medical Economics was that of the Malpractice Claims Prevention Committee. This group probably met more often than any other, except the executive committee, and its members made themselves available for assistance to more than 30 physicians throughout the year. There was an increase in the number of suits filed against physicians in the county, but at the same time it was noticed that there was a marked increase in the number of physicians who have become claims prevention conscious, and have used the committee's advice and services to their personal advantage in reducing the possibilities of litigation. The committee, in cooperation with leaders of seven other Northern California counties, successfully completed negotiations with the American Mutual Liability Insurance Company of Boston for a five-year extension of the present group contract, on terms which guaranteed that premiums during that period would not rise more than 25 per cent above the 1951 level.

In June, the Medical Economics Committee completed an agreement with National Casualty Insurance Company, whereby the monthly indemnity income for sickness or accident was raised from $225 to $300 per month, with a corresponding premium increase. This action was taken to help offset the income value of $225 lost through inflation. The subcommittee on prepaid plans gathered and distributed information of value in answering inquiries coming to the society on the availability of the various plans. One of the most intensive jobs of the year was done by the committee on the society's "C.P.S. Deductible Contract Plan." Although final action has not yet been taken by the membership, the committee has made an intensive study of possible means to provide a pilot program in cooperation with California Physicians' Service to determine if such a program, as envisioned by the committee, is practical to sell, service, and administer. Santa Clara County alone would be used for the experiment. The November membership meeting was devoted entirely to a discussion of the possibilities of such a contract. The committee members have worked long and hard throughout the year, not only among themselves and with representatives of all the specialty groups, but also with the Trustees of C.P.S.

The Committee on Ethical Conduct preferred charges on one member during the year, such charges being heard by the Council. The hearings were concluded prior to the Council's going out of office on December 10. The decision of the Council had not been released as of the time this report is prepared.

The executive committee and the Woman's Auxiliary advisory committee worked very closely in unifying the interests and programs of the two organizations during the year. The Council congratulates the Auxiliary for their splendid efforts in developing a program of gifts, and their assistance as "adopted parents" for youngsters at the County Hospital. Through closer correlation of the Auxiliary's and society's activities, even more material gains are anticipated during the coming months.

As the year drew to a close, the Building Project Committee of the society neared completion of its report on the possibilities of the society providing and financing a building which would house the various society's activities and Bureau of Medical Economics. The committee intends to recommend distribution of its report, when it is completed, to the entire membership.

Attendance of the county's delegates and alternates at the Annual Session of the C.M.A. in Los Angeles in May was again 100 per cent. At the newly inaugurated mid-year Interim Session (December 1 and 2), ten out of the 14 delegates and alternates were present. The hard work of this group during these sessions, and the praise which the delegates have received for their leadership in state association affairs deserves commendation from the entire membership.

The Council is especially appreciative of the constant help given by the San Jose *Mercury*, the San Jose *News* and the Palo Alto *Times*, in publicizing the activities of the society. The editors of all three papers have, on one or more occasions throughout the year, written special editorials directly praising both the work of the society and the current policies of the American Medical Association. The news columns of these papers have helped make more widely known the constant availability of services to the public from the medical society's business office and public service committees. The increasing dependence by the public upon the society is shown by the variety of requests which it has received during the year for assistance or services in many lines directly or closely associated with medical care services. The variety of requests increases with each passing year, and is as varied as the nominations to the Board of Supervisors for appointees to the welfare board, on down to the urgent one hour's notice to locate a "team-physician" to serve at a crucial high school football game, which could not have been played without a physician present.

During the year the society was able to "return" some of the help it had received in previous years from other county societies by loaning personnel to other areas seeking to start programs patterned after the Santa Clara County plan. Nearest to home was the assistance given to Monterey County. In the spring of the year the society's executive secretary was loaned to the Phoenix, Ariz., society for a ten-day period. Since that time, Phoenix has set up a program completely identical to that of Santa Clara County, to and including its own Bureau of Medical Economics. In December the American Medical Association selected the Santa Clara County's "guaranteed care for all" plan as one of the six major topics for discussion for its fourth annual Public Relations Conference held during the A.M.A.'s Interim Session in Los Angeles. The constant and frequent recognition of this society's activities by so many independent observers might well be considered a compliment for the programs which the officers and leaders of the society have instigated and kept in active force during these recent years.

WILLIAM L. MOLINEUX, *Secretary*

Santa Cruz County Medical Society

Dr. J. C. Jacobson of Santa Cruz served as our president during 1951 and a very successful year was recorded. As in the past the system of bimonthly meetings was continued. Meetings are held at Deer Park Tavern, Aptos, which is centrally located for members coming from both ends of Santa Cruz County. At the January meeting Dr. T. P. Lyon of San Jose presented the subject "Lipoproteins and Atherosclerosis." Dr. Albert Snell of Palo Alto was with us in March and spoke on "Cirrhosis of the Liver." The May meeting was a tri-county meeting with San Benito and Monterey counties and the speaker was Dr. Louis J. Regan who spoke on "Some Aspects of the Malpractice Program." In July Dr. H. Glenn Bell of the University of California presented a paper on "Cancer of the Breast." Dr. Charles Bechtol of Oakland was with us in September and spoke on "Painful Shoulders." The November meeting was the annual business meeting and, in addition, a film on ACTH was shown through the courtesy of Armour and Company. Dr. J. Ludden of Watsonville was elected to serve as president in 1952.

SAMUEL B. RANDALL, *Secretary*

San Mateo County Medical Society

During the year 1951 the San Mateo County Medical Society continued to grow in membership, reaching a new total of 307 active, associate and other types of members. The program committee produced a number of outstanding meetings during the year on both scientific and economic subjects which were climaxed by the annual meeting in December. Dr. Dan W. Boudett succeeded to the presidency with Dr. Alf T. Haerem being elected to president-elect and Dr. Bradley C. Brownson as secretary-treasurer. Continued growth at our present rate will make the society eligible for another delegate to the C.M.A. by November. The society's public relations program is moving along in full swing and has received very satisfying recognition by the general public.

ALF T. HAEREM, *Secretary*

EIGHTH DISTRICT

San Francisco County.

M. Laurence Montgomery, *Councilor.*

San Francisco Medical Society

The membership of the San Francisco Medical Society reached an all-time high in 1951. One hundred forty-eight new members were admitted between December 1, 1950, and December 1, 1951, bringing the total membership figure to 1,686. Twenty-one members died during the period, and leaves of absence were granted for postgraduate study, illness and military service to 41 others.

The new constitution and by-laws which went into effect January 1, 1951, created the offices of president-elect and assistant secretary-treasurer, the latter to become editor of *The Bulletin* of the S.F.M.S. as well. To fill these posts, the board of directors set March 12 as the date for a special election. Stacy R. Mettier, an internist, professor of medicine at the University of California Medical School and head of postgraduate instruction at the University of California Medical Extension, was selected as president-elect. He assumed the presidency on January 1, 1952. Herbert C. Moffitt, Jr., was elected assistant secretary-treasurer.

The administrative affairs as well as the many activities of the society expanded to such extent in 1951 that it very often was necessary for the board of directors to meet twice a month instead of once. In addition, the executive committee, between board meetings, held regular luncheon meetings to which were invited committee chairmen from time to time to discuss pertinent subjects carried on the agenda for the board of directors.

The principle of having a large percentage of the membership working on committees of the society was continued in 1951. It has been found that this "spread-the-work" policy increases active interest and participation in society affairs and seasons committee members for future posts.

Television, which is becoming so much a part of the American scene and way of living, posed a problem for the society in 1951. Requests for appearances on television programs became so numerous that it was necessary for the president and board of directors to create a committee on television. To determine feelings concerning the appearance of physicians on television programs, the committee sent a questionnaire to officials of the C.M.A., the society and to members of the faculties of the two medical schools. The general consensus seemed to be that the present rules of the society, with reference to the appearance of physicians before lay audiences were applicable to television appearances.

The society's tuberculosis minifilm unit completed its third year of function in 1951 with a total of films read during that period of 17,325, of which 16,688 read negative. Other findings included 49 active T.B., 154 inactive T.B., 180 clinically other disease, and 184 clinically negative.

The Irwin Memorial Blood Bank of the society serves the transfusion needs of the civilian and the majority of military hospitals in San Francisco, Marin, Napa and Solano counties. These hospitals are routinely stocked by the society's bank with blood of various types and with irradiated plasma. Through the clearing house of the California Blood Bank System, the bank further aids the transfusion needs of the people by maintaining reciprocity with the nine other member banks of the system, 11 out-of-state banks, and the eight Red Cross Regional Blood Centers of the Pacific Area.

Since September 1950, through October 1951, the society's blood bank has furnished 55,325 units to the Armed Forces Blood Donor Program, over and above the bank's services to its communities. This record rates third for

the country and is surpassed only by New York and Los Angeles which have much larger populations. The bank has been able to stockpile and store in subdepots, primarily hospitals in San Francisco and North Bay counties, over 1,000 units of dried plasma and sufficient blood bank equipment to procure blood from over 2,000 donors for civilian defense purposes.

Efforts continued during the year to improve *The Bulletin* of the society, and to encourage artist-members to contribute to it. Five out of 12 covers used in 1951 were reproductions of photographs or paintings by physicians. A new column entitled "The Drug Review" which outlines the therapeutic usage and dangers of the newer drugs, was introduced during the year.

In the spring, a testimonial dinner was given to John W. Cline, then president-elect of the A.M.A., and in the fall, a second dinner meeting was held with William Dock of the Long Island Medical College as the guest speaker. About five hundred doctors attended each dinner meeting, with entertainment being provided by members. These dinners also were attended by 40 junior physicians who were guests of the society, through its committee for young physicians.

The latter committee set up plans in June for a loan fund for junior physicians which was approved by the board of directors and, since that time, numerous requests for loans have been received and taken care of when the need was indicated. This committee also is working on a plan with the San Francisco Dental Society whereby a panel of dentists will provide the usual high standard dental care for junior physicians in training and their immediate dependents at reduced cost based on the veterans' dental fee schedule.

In the past two years an effort has been made by the San Francisco Medical Society through its union labor committee and various representatives of the unions of the San Francisco Labor Council to work out a health and welfare plan for their members. A fee schedule that was set up is probably one of the highest for insurance work in the United States. However, neither the doctors nor the unions are 100 per cent satisfied with the results. Further meetings may iron out the "bugs." The principles as set down by the board of directors of the society regarding these health plans are as follows:

1. That all members of the society may participate. There shall be a free choice by physician which means no panels selected either by the insurer, a lay group, or the society.

2. That there must be no set or frozen fee schedule. The individual doctor's right to establish with his patient the fee to be paid must be respected.

3. There can be no third party placed in the middle of the all-important and confidential doctor-patient relationship.

4. The society will not participate in any capacity with any prepayment plans that fail to distinguish between physicians and surgeons and other types of practitioners.

5. The society, within these principles, stands ready at all times to advise and assist in all professional matters related to prepayment plans.

Under the direction of President Garnett Cheney, some 40 committees have been hard at work throughout the year, carrying out their assignments with diligence and dispatch. These committees constitute the backbone of this society, and credit for any good work done by this organization belongs primarily to them.

The aim of this society, in 1952, as expressed by the president, Stacy R. Mettier, is to endeavor to establish a closer and better relationship between the society and the people of the Bay Area, in addition to carrying on the excellent work of the past year.

ALLEN T. HINMAN, *Secretary-Treasurer*

NINTH DISTRICT

Alameda and Contra Costa Counties.

Donald D. Lum, Alameda, *Councilor.*

Alameda-Contra Costa Medical Association

The projects and accomplishments of this association are well covered in the report of Dr. Donald Lum, Councilor of the Ninth District, which appears under Report of Councilors.

HAROLD P. MALONEY, *Secretary-Treasurer*

TENTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Solano and Sonoma Counties.

John W. Green, Vallejo, *Councilor.*

Humboldt County Medical Society

Under the very capable direction of President Herbert L. Moore, 1951 proved to be a year of considerable activity for all society members. There being a wealth of business matters which demanded prior attention, topics of academic interest were not too frequently presented at regular society meetings. However, since hospital staff meetings are so well attended, we have benefited from some excellent discussions on subjects of medical import.

In the interest of improving facilities for the care of patients in our county; of establishing improved rapport between the medical profession and labor and thus indirectly of furthering efforts to preserve our status as friends and counselors as well as healers of disease, the following work has been done by the society:

1. Development of an average, current fee schedule as applied to the general practice of medicine and available to our "Grievance and Ethics Committee."

2. A brochure for general distribution designed to stimulate patients in properly interpreting health and accident insurance coverage.

3. A resolution that the C.M.A. recommend that all prepaid health insurance companies give office and ambulant cases more coverage for diagnostic procedures so as to eliminate and prevent a growing trend of unnecessary hospitalization.

4. Organization of the Northern California Community Blood Bank and participation in the Armed Forces bleeding program.

5. A committee of physicians which regularly meets with representatives of labor and with health insurance representatives in order to detect any instance of physician abuse of the health insurance program, unreasonable demands by policyholders or their dependents, or misrepresentation of insurance coverage.

6. Establishment of a medical library available to all society members; centralization of care for cases of poliomyelitis.

President, vice-president, secretary and treasurer for the year 1952 are Francis O'Neil, E. Kenneth Smith, John W. Schonwald and Allan Watson respectively.

JOHN W. SCHONWALD, *Secretary*

Marin County Medical Society

Nineteen fifty-one was a worthwhile year marked by well programmed and attended meetings by 85 members under the able leadership of Warren L. Bostick. The presence of the members' wives at the dinners preceding the meetings has made each an event anticipated with pleasure.

Marin was host this year to the societies of Napa, Solano and Sonoma counties at the annual four-county meeting and golf tournament, at which Dr. John Cline was the guest speaker. The organization of the new Marin General Hospital is functioning well, and it is anticipated that the hospital will be receiving patients this summer. The hospital library will be named in memory of our former secretary, Carl W. Clark.

WILLIAM BURGETT SMITH, *Secretary-Treasurer*

Napa County Medical Society

Under the leadership of President Charles W. Brown our society had a successful year. There was some increase in membership which was sufficient to allow for an extra delegate to the state convention.

The meetings were held at monthly intervals with the exception of two summer months which past experience showed were poorly attended. Good programs were presented and good fellowship existed throughout the year.

During the year the society suffered the loss of two of our most honored members, Dr. Richard C. Burkett and Dr. Charles H. Bulson. Their death was a great loss to the society and the community.

As usual in November our annual meeting for the election of officers was held at the Veterans' Home, whose hospitality was enjoyed by all those present. At this

meeting Dr. Dale E. Barber was elected president for the coming year, Herbert B. Messinger, vice-president, and the undersigned secretary was reelected. Delegates to the convention were Dale E. Barber and George I. Dawson; alternates, Herbert B. Messinger and Walter H. Brignoli.

The December meeting was in the nature of a testimonial dinner for Dwight H. Murray, a member of our society for many years who is now giving powerful service to the A.M.A. as chairman of the board of trustees. This meeting was attended by many men prominent in the profession and in business life throughout the northern part of California. Several addresses were made by prominent men extolling the fine work which Dr. Murray has done for medicine in fighting socialism in all forms.

We hope the coming year will be equally successful.

ROBERT S. NORTHRUP, *Secretary*

Solano County Medical Society

The activities of the Solano County Medical Society were under the able guidance of their president, Dr. John G. Garthe, and Dr. Lionel W. Johnson, who was responsible for arrangement of a variety of good programs and outstanding speakers for the society. Dr. R. M. Gibbons, vice-president of the society, assisted Dr. Johnson.

Among the foremost accomplishments was the good attendance of each monthly meeting as well as the close relationship with the doctors situated in the surrounding military establishments who made a concerted effort to attend some of the scientific meetings in relatively large numbers.

Early in the year there was considerable activity pertaining to civilian defense planning and organization for possible disaster. The society went as far as establishing temporary casualty centers and assigned each member of the society to a particular center so that every member knew where he would be expected should the need arise.

The Solano County Medical Society accepted a plan for sickness-health insurance pertaining to individual members. Some 35 members subscribed to it.

The society continued to sponsor a team in the Peanut League this year as in the previous year.

The society also established the Solano County Chapter of the California Division of the American Cancer Society.

Prominent speakers addressed the society:

Dr. Paul Michael, pathologist of Oakland, spoke on Liver Tests and Their Relative Merits.

Dr. Edward B. Shaw of San Francisco spoke on the Treatment of the Common Communicable Diseases.

Dr. Vance Strange and Dr. W. W. Washburn spoke on Peripheral Vascular Disease and Indications for Lumbar Sympathectomy.

Dr. Clark, of Lederle's Laboratories, spoke on the use of Aureomycin, Chloromycetin and Terramycin.

Drs. Earl and Norman Lussier of San Francisco spoke on the Edentulous Jaw and the Use of Vitallium Implants.

Dr. Wartenburg spoke on Office Neurology.

The September meeting was under the auspices and in cooperation with the Cancer Commission, California Division. The society was addressed by Dr. Franklyn Hill, the director; Dr. Leonard G. Dobson spoke on the Management of Carcinoma of the Skin; and Dr. David A. Wood spoke on Early Detection and Diagnosis of Accessible Site Cancer.

The October meeting was highlighted by a visit from the president-elect of the California Medical Association, Dr. L. A. Alesen, who addressed the society on vital economic problems and public relations. Messrs. Ed Clancy and Glenn W. Gillette of the Public Relations Department, C.M.A., also spoke on the same subject.

A pre-Christmas and final meeting of the year was held in December at the Green Valley Country Club in conjunction with the ladies' auxiliary of the Solano County Medical Society. John K. Chapel, noted radio commentator from Oakland, addressed the society on current national events and on the Korean situation.

Among the new members admitted to the society were Dr. Van Buren of Benicia, Dr. Garrett of Vallejo, Dr. Cook of Dixon, and Dr. Zimmerman of Fairfield.

New officers elected for 1952 were Dr. H. Lammell, president; Dr. Lionel W. Johnson, vice-president; Dr. Wm. R. Hoops, secretary-treasurer.

IRWIN M. SHANKMAN, *Retiring Secy.-Treas.*

Sonoma County Medical Society

The year 1951 will be remembered by the Sonoma County Medical Society as its "year of achievement." The pioneering efforts of the previous two years were brought to fruition by the hard work and inspiring leadership of Horace F. Sharrocks, president.

In June 1951, a central office was established to keep up with the expanding activities of the society, with Mrs. Thomas Quayle as secretary. F. Leslie Manker, local practicing attorney, was again able to devote part time as our executive secretary to guide the activities of the office and advise the society legally, particularly in cases studied by the very active Medical Economics and Medical Protective committees.

During the year the society entered into a contract with the American Mutual Liability Insurance Company to provide malpractice and premise liability insurance to members at reasonable rates, under a plan in which every effort is made to adjust complaints before court action is filed.

A contract with the Redwood Empire Adjustment Bureau for the collection of doctors' accounts has proved mutually advantageous.

In December, because of its expanded activities, the society was incorporated.

Thirteen new members were admitted during 1951, bringing the total active membership to 113.

The emphasis on public relations, especially with the local press, was continued and, with the help of Mr. Glenn Gillette, Associate Director of Public Relations, California Medical Association, a code of cooperation with the newspapers was formulated. Organization of a speakers' bureau was started, a study of night and emergency calls was made and liaison established with lay organizations concerned with matters of public health, the practice of medicine, and so forth.

Intrasociety relations were improved by the expanded development of the *Bulletin*, by the approval of a new constitution and by the presentation of excellent scientific programs at the monthly meetings. The speakers included: Drs. Robert S. Stone, John Gibbs, Horace McCorkle, H. E. Parsons, L. D. Howard, Philip Arnot and Carl Anderson.

An instructive two-day Medical and Surgical Institute, sponsored by the California Medical Association, was held in March, and special meetings were held with the Woman's Auxiliary, including the annual barbecue, in July, at the home of Dr. and Mrs. William Makaroff.

The annual visit of the California Medical Association's officers, including Dr. Lewis Alesen, president-elect; John Hunton, executive secretary; Ben Read, Ed Clancy and Glenn Gillette, was a memorable one.

WILLIAM J. RUDEE, *Secretary*

ELEVENTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Yolo and Yuba Counties.

Wayne E. Pollock, Sacramento, *Councilor.*

Butte-Glenn County Medical Society

The Butte-Glenn Medical Society has been handicapped in this past year due to a change in officers in mid-season, but by the end of the year had quite an admirable record. Dr. Dean Holland, president for this year, was drafted into the U. S. Army in May. Because of his impending draft he was unable to accomplish much during the first five months. Dr. Meredith Guernsey, who succeeded him as president, has been most active and under his guidance all committees were reapppointed and functioned very well. During this year we have established a new malpractice insurance-prevention program under the American Mutual Liability Insurance Co. At least two meetings have been devoted to the malpractice prevention program. The Butte-Glenn Medical Society has also set up a disability insurance program optional for all members. Poliomyelitis is now being treated in the Butte County Hospital under the guidance of the polio and public health committees and in cooperation with the Public Health Department. The Public Health Department under Dr. John Philp has been most active. New offices are completely equipped and functioning in both Oroville and Chico and the tuberculosis and public health education programs are well under control. The blood bank in the Butte-Glenn County area

is now operating very well in all four hospitals. A few minor technical difficulties have been ironed out and anyone in urgent need of blood can now receive same immediately. In the interest of good public relations a more active public service committee has been appointed for the latter part of 1951 and 1952. The public relations committee has instituted a radio program in the local Chico radio station, KXOC, devoting fifteen minutes' time every week to further good medical public relations. Dr. Meredith Guernsey has been elected as president of the Butte-Glenn Medical Society for the year 1952. Dr. Donald Casey is the vice-president and Dr. W. C. Chiapella, secretary.

W. C. CHIAPELLA, *Secretary*

Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc Medical Society meets on call of the president. This is necessary because of the 200-mile-long territory involved and the variable road conditions. Three very interesting meetings were held during 1951. The first in the spring in Alturas was attended by one-third of the membership. Dr. Harper of Reno lectured on surgery in spastic conditions. The second meeting was held in conjunction with the Cancer Conference at Susanville. Guest speakers were John M. Kenney, M.D., of Stanford University School of Medicine, and Robert S. Pollack, M.D., of the University of California School of Medicine. The meeting was very much enjoyed by all attending. On November 17 Dr. Lewis A. Alesen, President-elect of the C.M.A., spoke to a good attendance of members and their wives at Susanville. All deeply appreciate his presence and stimulating speech. Short informative talks were given by John Hunton, Executive Secretary of the C.M.A.; Glenn W. Gillette, Associate Director of Public Relations of the C.M.A., and Ben H. Read, Executive Secretary of the Public Health League. Dr. J. W. Crever presided. Much appreciation is felt for the efforts of the speakers in attending our rather remote meetings.

ALLEN E. PRIEST, *Secretary*

Placer-Nevada-Sierra County Medical Society

Placer-Nevada-Sierra Medical Society held regular monthly meetings on the second Wednesday of each month, except for July and August of 1951. One meeting (June) consisted of a medical cancer symposium sponsored by the California Medical Association Cancer Commission and the California Division of American Cancer Society.

The November meeting was a dinner meeting held in conjunction with the election of officers.

Officers elected for 1952 are as follows: Vernon Padgett, Grass Valley, president; Carl Jackson, Auburn, vice-president; and T. J. Rossitto, Auburn, secretary-treasurer.

T. J. ROSSITTO, *Secretary-Treasurer*

Sacramento Society for Medical Improvement

Organized in 1868, our society is the oldest medical society in the state of California and has enjoyed steady growth since its inception. The society now has 272 members, many of whom are active in local and state medical affairs. Society meetings are held on the third Tuesday of every month, at which time speakers aid in keeping the membership informed of recent developments. An annual banquet is held on March 17, St. Patrick's Day, the anniversary of the foundation of the society. The December meeting is an annual business meeting, at which time the board of directors and C.M.A. delegates are elected. The officers are then elected from among members of the board at the January board meeting.

A history of the society, which includes a great many factors of interest to California medicine in general, has been written by a society member, J. Roy Jones, M.D. The history is in the form of a book entitled "Memories, Men, and Medicine" which has been published by the Sacramento Society.

As another milestone in progress, the society in 1950 hired a full-time executive secretary and launched a broad and extensive public relations program. As part of the program it has publicly announced an unqualified guarantee to every resident of the community of good medical care, 24 hours a day, regardless of ability to pay.

EDMUND E. SIMPSON, *Secretary*

Shasta County Medical Society

The Shasta County Medical Society now has 25 active members. During the past year there were two deaths and three new admissions, and two members of the society went on active duty with the armed services. Officers for 1952 are: J. L. Price, president; J. M. Kehoe, vice-president; and H. R. Eagle, secretary-treasurer.

Regular meetings of the society are held on the first Monday of each month.

H. R. EAGLE, *Secretary-Treasurer*

Siskiyou County Medical Society

Nineteen fifty-one was marked by the formation of the first organized medical staff at the Siskiyou County General Hospital, Yreka. The staff is open to and governed by all members of the Siskiyou County Medical Society.

The society enjoyed the meeting with Dr. Pollock, Councilor; Mr. Ben Read, Executive Secretary, Public Health League of California; Mr. Ed Clancy and Mr. Glenn Gillette, public relations representatives; and Dr. L. A. Alesen, president-elect in November 1951 and receiving directly from them statements as to the problems and policies of the California Medical Association.

D. L. MEAMBER, *Secretary-Treasurer*

Tehama County Medical Society

Tehama County is fortunate in having added approximately 40 new beds which is a considerable increase for a county of twenty thousand. A new district hospital of 25 beds has been constructed at Corning in the southern part of the county which will greatly facilitate medical and hospital care in that area. This hospital will be opened in January 1952. A new wing is being built on the St. Elizabeth Hospital in Red Bluff with an addition of approximately 15 beds and modernization of the main building is also being done.

O. T. WOOD, *Secretary*

Yolo County Medical Society

The Yolo County Medical Society held regular monthly meetings during the year except in July and August. At each meeting a paper was presented and a discussion was held by outstanding medical men on a variety of subjects related to the practice of medicine. One meeting was presented by the Cancer Committee of the society with the help of the National Cancer Education Campaign. One meeting was devoted to a diagnostic clinic for tuberculosis and other chest diseases supported by the Yolo County Tuberculosis Association. One meeting was partially devoted to a discussion of physician-patient relationships by a team of officers from the California Medical Association.

The society was active in support of the procurement of a full-time public health officer for Yolo County. Dr. John Rafferty was appointed to this position in May.

New members admitted during the year were Drs. Robert L. Pye, William T. Robinson, John F. Hollister, Spencer T. Chester, Donald E. Wyrens, Eugene W. Kenney, and John Rafferty.

RICHARD J. CUNDIFF, *Secretary*

Yuba-Sutter-Colusa County Medical Society

The beginning of the year 1951 found our Medical Society nicely located in its own exclusive building, the use of which has been donated to our society by Mr. Fred Moore, manager of the Rideout Memorial Hospital. The official meeting place is known as the Rideout Memorial Cottage. Subsequently, a committee was appointed which, from a society check for $500, purchased furnishings for our meeting place.

During the year, a physician's widow has been regularly receiving a benevolence check through the courtesy of the C.M.A. Benevolence Committee.

The guest speaker at our January meeting was Dr. Charles Blumenfeld of Sacramento, pathologist, who showed lantern slides on the special technique of cervical cancer smears.

The guest speaker for February was Dr. Joseph Giansiracusa, assistant professor of medicine of U. C. His subject was clinical use of ACTH and cortisone.

The March guest speaker was Dr. Joseph H. Harris, State Mental Hygiene Clinic. A medical motion picture was also shown, on gastrointestinal cancer.

Emergency medical service, on a rotating physician basis and a 24-hour schedule, has now been in operation for the past two years, and has been very satisfactory to all concerned.

The secretary attended the annual conference of county medical society secretaries and made a complete report to the society at the April meeting.

At the April meeting, a preview showing of a film on technique of examination in breast cancer was given and it was approved for showing to women's organizations. A fee of $7.50 for Civil Service examinations, including urinalysis, was approved, and all members were given written notice accordingly.

Meetings were not held in June or July.

A business meeting was held in August, and it is a matter of record that we disapproved the loaning of medical text-books to attorneys.

Our annual dinner meeting with the Auxiliary was held on October 11 and the following guests were present: Lewis A. Alesen, M.D., President-elect, C.M.A.; Mr. Ed Clancy, Director of Public Relations, C.M.A.; Mr. Glenn W. Gillette, Associate Director Public Relations, C.M.A.; Mr. Ben Read, Executive Secretary, the Public Health League of California.

Guest speaker at the November meeting was Dr. Edwin J. Wylie, U. C. His subject was Peripheral Vascular Disease Surgery.

A business meeting was held in December, at which time the following officers for 1952 were elected: President, Robert L. Ayers; vice-president, Charles B. Kimmel; secretary-treasurer, Leon M. Swift; delegate, Stanley R. Parkinson; alternate, Joseph J. Salopek.

Considerable A.M.A. literature was distributed by the local members during 1951. At the December meeting, Dr. Francis P. Wisner presented in detail the civilian medical defense program, which is now set up on a standby basis, ready for emergency call at any time disaster should strike.

LEON M. SWIFT, *Secretary*